Address in Obstetrics

DELIVERED AT THE

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BY

SIR JOHN W. BYERS, M.A., M.D.,
M.A.O. (HON. CAUSÂ),

PROFESSOR OF MIDWIFERY AND OF DISEASES OF WOMEN AND CHILDREN IN QUEEN'S COLLEGE BELFAST; PHYSICIAN TO THE BELFAST MATERNITY HOSPITAL; PHYSICIAN FOR DISEASES OF WOMEN TO THE ROYAL VICTORIA HOSPITAL, BELFAST; CONSULTING PHYSICIAN TO THE BELFAST HOSPITAL FOR SICK CHILDREN.

THE PRESENT POSITION AND THE FUTURE DEVELOPMENTS OF OBSTETRIC MEDICINE.

My first duty is to thank the British Medical Association for the compliment it has paid me in inviting me to deliver the Address in Obstetrics. I feel the responsibility of my position all the more as I am confident that in selecting me the Association wished to honour that branch of medical science which, owing to the unique facilities afforded in Ireland for clinical investigation and study in maternity hospitals, has come to occupy with us a position of acknowledged pre-eminence.

Occasions like this great medical meeting present fitting opportunities for reviewing the position at present occupied by the three divisions of the healing art—medicine, surgery, and obstetrics; for recording what real progress has been made in each branch; for discussing calmly and scientifically various new views, especially those pertaining to treatment; and, finally, for suggesting the lines of advance along which we may hope for still further success.

It is indeed quite unnecessary for me to say anything as to the importance of obstetric medicine, which the majority of the medical profession have to practise. Apart altogether from the fact that those engaging in this branch of practice have the great responsibility thrown on them of dealing at the same time with the fate of two lives, the modern obstetrician, in addition to possessing a sound knowledge of all the sciences ancillary to medicine, must cultivate the keen power of observation and must enjoy the education and have the special training necessary to draw correct inferences—qualities supposed to be the special prerogatives of the physician—while, at the same time, he must be imbued with the scientific accuracy and make himself master of the perfect technique and the skilled handicraft of the surgeon.

Now, keeping constantly in mind that *the ideal to be aimed at in obstetric practice is not merely a living mother and a living child, but rather a living healthy mother and a living healhy child*, I propose to-day to endeavour to place before you in some of its bearings the present position of obstetric medicine and surgery, and to throw out a few suggestions, the adoption of which, I venture to hope, would lead to still greater progress in the future. A consideration of both these aspects of the subject—the present position and the future developments of obstetrics—will convince you, I believe, that Bacon's famous aphorism, "Medicine is a science which has been, as we have said, more professed than laboured, and yet more laboured than advanced; the labour having been, in my judgement, rather in circle than in progression,"[1] does not apply to obstetrics.

I. The Present Position of Obstetrics.

It was exactly a quarter of a century ago that, in this very room, on the occasion of the first meeting of the British Medical Association in the North of Ireland, of which I was one of the honorary secretaries, a very interesting address in obstetrics was delivered by one who at that time was the recognized head of his own speciality—the late Dr. George H. Kidd, ex-Master of the Coombe Lying-in Hospital, Dublin. Taking that address as a landmark, and as the expression of the views of a most thoughtful and practical obstetrician, let us ask the question, How does the science of obstetrics stand to-day as compared with its condition in 1884? I will endeavour to answer this query by considering three problems of obstetrics—puerperal infection, operative midwifery, and some of the complications of labour.

(A) *Puerperal Infection.*

Dr. Kidd selected as the subject of his address in 1884 "Puerperal Fever," which is probably still the most important question in obstetric medicine; and, while he spoke of traumatic cases of this disease, of types due to organic substances retained in the uterus, and of other forms where the disease originated in varicose veins (phlebitis), he dealt specially with epidemics of puerperal fever; and, quoting the definition of epidemic disease from the New Sydenham Society's *Lexicon* as "a disease prevalent among a people or a community at a special time, and produced by some special cause or causes not naturally or generally present in the affected locality, as distinguished from an endemic disease," he arrived at the conclusion that there was a large group of puerperal cases that came strictly within this definition, and that the epidemic thus constituted was a specific disease. He gave an account of one such epidemic which occurred during 1854–5 at the Rotunda, and which was described by Dr. McClintock, and he also gave his own experience of another at the Coombe in 1880. Dr. Kidd also discussed the septicaemic theory as to the nature of puerperal fever, which seemed to him to be defective, and pointed out that "those who hold it look on the disease as preventable, and assert that its occurrence is due either to ignorance of the precautions necessary to prevent it, or to failure in seeing that such precautions are rigorously carried out"; but, at the same time, he added, "The history of great hospitals, such as that of Dublin and Vienna, shows that puerperal fever will prevail and cause sad mortality at times, and disappear again, and that the conditions governing its movements have not yet been discovered."[2]

A quarter of a century has passed since Dr. Kidd's able address was delivered, with the result that we now know not only the nature of puerperal fever and the conditions relating to its etiology, but—what is of infinitely greater practical importance—we have mastered the methods by which it can be prevented, and we see that epidemics of this disease do not now occur. We no longer use the term "puerperal fever," because it conveys the suggestion that it is a specific malady—analogous to scarlet fever or typhoid—and because it lays too much stress on its thermometric phenomena. We, at the present time, employ the words "puerperal infection"—in order to draw special attention to their communicable nature—as defining those protean morbid conditions due almost invariably to the entrance of various kinds of micro-organisms into the parturient canal before or at labour, or during the puerperium, introduced as a rule by fingers, or instruments, or any other object, which are not surgically clean, or by sterile fingers or instruments from insufficiently cleansed labia minora. Maternity hospitals have no longer epidemics of puerperal infection, and we now measure the success of the technique employed at these institutions much more accurately by their morbidity than even by their mortality, the reason being that some deaths at childbirth are still due to accidents and complications, which cannot, with the means at present at our disposal, be avoided, while, on the other hand, the great proportion of childbirth illnesses are due to want of proper surgical cleanliness, and, as we shall see, can be, to a large extent, prevented.

Puerperal Morbidity.

It is a great pity that, for the purpose even of statistical comparison, the various maternity hospitals are not agreed as to the physical indications of puerperal septic morbidity. This is well seen in the report of the Committee on Puerperal Morbidity,[3] appointed at the annual meeting of the British Medical Association in Leicester in 1905. Information was received from maternity hospitals in England and abroad in regard to the standards of puerperal morbidity which they recognized, but from the utter diversity of the replies it was clear that efficient comparison of the statistics of these institutions would be impossible. For example, some thought such a standard was "useless," others that it was "desirable, but hardly practicable, no one factor being sufficient in itself." Some replied "every case must be judged on its merits," others that "the only accurate method will be by having bacteriological examination of the lochial discharge," or "offensive lochia"; or "the rise of temperature above 100.5° F., persisting for more than forty-eight hours, should be regarded as indicative of infection, unless it can be clearly

demonstrated to be due to some other cause. If the rule were adopted that all such cases should have a leucocyte count, uterine cultures and blood cultures, a positive result might clearly determine which febrile cases are septic"; while, in opposition to such a rigorous criterion, some said, in reply to the question, "Have you any suggestions as to general adoption of a standard for use in maternity hospitals to serve as an index of septic morbidity?" "No. Every one who is fit to be in charge of a lying-in hospital is capable of deciding this, and a standard is, in my opinion, useless"; and another reply to the same query was "No. The diagnosis of septic morbidity is usually easy enough to the unprejudiced observer." The majority of the maternities, however, regarded pulse, and especially temperature, as the best and most easily available evidence of puerperal morbidity. In a paper, "A Plea for the Early Recognition and Treatment of Puerperal Fever" (published in the *Lancet*, August 22nd, 1896), I pointed out that the early symptoms of puerperal infection were elevation of temperature and quickness of pulse; and while I mentioned certain intercurrent non-septic conditions which might raise the pulse and temperature after delivery (giving, at the same time, the diagnosis between them and cases of puerperal infection), I wrote: "I think, then, if we exclude conditions such as I have mentioned, and which, after all, are not very common, we are warranted in concluding that it is, on the whole, rare to have fever and quick pulse in the first five or six days after labour from any other cause than infection." The Committee on Puerperal Morbidity appointed by this Association made the following recommendations:

1. That irregularities in temperature occurring during the twenty-four hours following delivery should not be considered for statistical purposes.
2. That as the time puerperal patients remain in hospital varies in different institutions, statistical tables should be formed from the records up to the end of the eighth day after delivery.
3. That statistical records should relate only to patients delivered after the sixth lunar month of pregnancy. (It is recommended that cases delivered before the end of the sixth lunar month of pregnancy should be tabulated separately.)
4. That records of pulse and temperature should be taken twice a day in every case, the following precautions being observed:
   (*a*) The temperature to be taken night and morning: if possible, between the hours of 7 and 9 a.m. for the morning, and between the hours of 4 and 7 p.m. for the evening record.
   (*b*) The temperature to be taken in the mouth.
   (*c*) The thermometer to be kept in the mouth for four minutes.
5. That the title of puerperal morbidity should include all fatal cases, and also all cases in which the temperature reaches 100° F. on any two of the bidaily readings from the end of the first to the end of the eighth day after delivery.
6. That all cases which according to this convention are "morbid" should be tabulated in statistics, the probable cause of the illness and its duration in days being given.

This may be called the British Medical Association standard. On the other hand, at the Rotunda Hospital, in deciding what is the morbid indication, a more certain criterion in the Master's opinion is adopted, and regard is had both to pulse and temperature. If a patient's temperature and pulse, taken twice daily, rise above 99° F. and 90 respectively on three consecutive occasions, counting from the beginning of the second day to noon on the eighth (the time normal cases are discharged), she is regarded as being morbid. Abortion cases are included, but patients dying without fever are excluded. If a patient's pulse and temperature exceed these limits, she is not allowed to leave the hospital until they fall to normal for three consecutive takings, and should a patient be retained in hospital after the eighth day and then show any morbidity, she is reckoned in the morbidity statistics. Temperature and pulse must together rise above these limits and remain above them for three consecutive bidaily takings, or, to put it another way, for twenty-four hours, before a case is regarded as morbid, the temperature being always taken in the mouth. In this way transitory and unimportant elevations of pulse and temperature (to which it would be unfair to apply the term "morbid") are excluded, and further, the irregularities of pulse and temperature often met with in the twenty-four hours after delivery are also excluded. Now, with the exception of certain transitory nervous influences and the presence of intercurrent maladies wholly independent of the puerperal state, in the great majority of cases as defined in this way by the Rotunda standard of morbidity the cause is infection by micro-organisms or by the toxins of retained lochia. So far back as 1891, in a paper on "Puerperal Fever, its Nature, Prevention, and Treatment,"[4] I used these words: "The experience I have gained at the clinic in diseases of women at the Royal Hospital and in private practice has brought prominently before my attention the fact that many of the chronic ailments of women are traceable to some feverish attack which sets in after parturition." Subsequent knowledge, acquired in the Belfast Maternity Hospital and in the Gynaecological Ward of the new Royal Victoria Hospital, has shown me that a large number of those affections of an inflammatory nature to which we give the term "pelvic inflammatory disease" in women, are cases of puerperal infection which, when they occur in a maternity institution, cause its "morbidity," and which, with a more complete aseptic and antiseptic technique, will in time be banished from lying-in hospitals as well as from private practice. These are the cases of child-bed illness which so often ruin health, which cause an immense amount of invalidity and chronic suffering, and which, it is estimated, constitute at least one-third of hospital gynaecological patients. When I studied at the Rotunda Hospital no clinical thermometers were in use; it was in the year 1882 that they were first introduced, and, as pointed out by Dr. Tweedy,[5] the note-book of the Assistant Master of that period, which I have inspected, shows that, of 99 cases in which the temperature was taken, in no less than 50 per cent. there was morbidity, 9 had temperatures of 105° F., and 18 temperatures of 103° F., yet the Master reported the condition of the hospital of that date as having been "particularly healthy."

Now, let me contrast the year 1884 (when the British Medical Association met last in Belfast) with the present time as regards mortality and morbidity in two Irish maternity hospitals. In the year 1883–84, from November 1st to October 31st (Arthur Macan, Master), 1,109 patients were confined in the Rotunda Hospital, with 9 deaths, and of these 1,109 there were 281 in whom the temperature was over 100.4° F., and the percentage of morbidity was 25.34. In the last year of which we have records, from November 1st, 1907, to October 31st, 1908 (E. Hastings Tweedy, Master), 2,060 patients were confined in the Rotunda Hospital, with only 7 deaths, and in only 126 was the temperature over 100.4° F.—that is, a percentage morbidity of 6.12. Of the 7 deaths, only 3 were due to infection (one was admitted infected, another had been examined outside, and the third was a case of incomplete abortion with a fetid discharge on entering hospital). It will be seen that, with nearly double the number of patients, there is less than half the number of actual morbidities, and also fewer deaths. As the present Master of the Rotunda points out in a letter to me, these results are better than the figures actually show, because:

1. Many patients formerly left the hospital on the fifth day, an occurrence now almost unknown.
2. The old thermometers did not register under six minutes, and, as a result, they were often taken out too soon. Further, they were placed in the axillae and not in the mouth, as at present—a method which gives a much more accurate record.
3. The present nurses at the Rotunda are much better educated than those of bygone days; they live in the house and are more thoroughly supervised, and, as a consequence, more reliable observations are made.

It is very interesting to note how the "morbidity" is gradually failing in the Rotunda, as shown by the following table. The estimate is made according to the Rotunda method.

Years.	Morbidity.
1903-4	10.70 per cent.
1904-5	6.67 ,,
1905-6	4.33 ,,
1906-7	3.99 ,,
1907-8	3.64 ,,

In former years in Belfast there were so-called epidemics of puerperal fever in our Maternity Hospital, necessitating its being closed on several occasions, and numerous cases which would now be classified as examples of "morbidity." At present such a state of affairs is unknown, and in our new, much-enlarged hospital, where both students and pupil midwives are trained, we had, during 1907 and 1908, 12 deaths out of 1,355 deliveries, and of these only 4 deaths were due to puerperal infection. (In

one the patient had been in labour for twenty-four hours, attended by an unqualified woman before admission; another, with a contracted pelvis, had been in labour several days before admission; and in a third, the child was born in an advanced state of decomposition.) Further, in 1908, our cases of morbidity from every cause, estimated on the standard that the occurrence of one temperature of 100.4° F. indicated a pathological condition, were 9.42 per cent., which is distinctly lower than at Hofmeier's well-known clinic. Again, owing to the aseptic and antiseptic management of the mother during her confinement, as well as by the adoption of special prophylaxis in the care of the child, cases of ophthalmia neonatorum in both maternities are now extremely rare.

These statistics show the present condition of obstetric medicine as practised in two Irish maternities—the Rotunda in Dublin, the largest midwifery institution in the British Empire, and in the Maternity Hospital, Belfast, in both of which students and midwives receive practical training. How have such splendid results been brought about in getting rid of that terrible scourge so often termed "puerperal fever," and in reducing the number of cases of morbidity? Simply by the careful and thorough carrying out of a series of details evolved step by step in the great campaign against infective microbes.

1. By recognizing, as was so well taught by the great Viennese obstetrician, Boer[6] (who really acquired the knowledge largely when visiting France and this country), that, in at least 75 per cent. of the cases, labour is a natural process not needing interference, and that its tendency is to prevent infection, and that our duty is to follow and aid it, and to interfere only when the resources of Nature fail to protect the interests of mother or child. The uncalled-for use of the forceps, early rupture of the membranes, douching—unless under very special circumstances—and the improper management of the third stage of labour, are things of the past in properly conducted maternities.

2. By the thorough application of the most minute surgical cleanliness as regards patient, nurse, and doctor during labour and the puerperium.

3. By the adoption of Credé's teaching, enunciated so far back as 1886, when he wrote, "Even the simplest manipulation may cause infection. It should, therefore, be laid down and taught as a fundamental principle that internal examination of parturient women should be altogether avoided or restricted within the narrowest possible limits. It can be very well replaced by external examination. To instruct their pupils as thoroughly as possible in this method is the present and future duty of teaching institutions."

4. By the immediate suture of any laceration occurring during the process of labour.

In my opinion, the most scrupulous surgical cleanliness in all manipulations, the thorough sterilizing of every article coming in contact with the patient, the greatest possible employment of the external methods of examination, and the strict limitation of internal examinations to cases in which the external plans have failed to give the necessary information, combined with the use of rubber gloves (recollecting, however, that sterile fingers, even when covered with recently boiled rubber gloves, may carry in infective bacteria unless the utmost care is taken to prevent contact with the inner surface of the labia and borders of the hymen), despite F. Ahlfeld's views[7]—these are the most important elements in the technique of a modern maternity hospital for the prevention of septic mortality and morbidity.

Professor Hofmeier,[8] estimating the puerperal morbidity on the basis that any case which shows even for once a temperature of 100.4° F. must be regarded as pathological, recently pointed out that the percentage of morbidity at the Wurzburg clinic was 11.48; while Scanzoni found that, out of a series of 157 precipitate births, 21.6 per cent. of 97 women who were never touched vaginally by any examining finger at all had a rise of temperature of between 102° and 104° F.; while of 112 parturients, who were confined without any contact from without, 11.5 per cent. had a rise of temperature up to 102.5° F., which it is presumed arose from infection. From such facts the conclusion might naturally be drawn that, do what we will, the woman who is confined can infect herself. But, on the other hand, it may be said that some of these supposed examples of autoinfection may have arisen from external sources after delivery, during the puerperium, as it was in this way that the morbidity of 10.7 in 1903–4 at the Rotunda had its origin in great part after the birth of the children. No doubt a very small proportion of septic cases may, during the lying-in period, seem to be examples of autoinfection. I have seen a case where in a primipara a rise of temperature was proved to be owing to the infection of the uterus with the pneumococcus, and, what was still more curious, the baby suffered from a bronchopneumonia. In another case a lady was infected from a septic phlebitis of the veins of the vulva which were inflamed before her confinement. The Master of the Rotunda has had similar cases, but that such so-called cases of "autoinfection" must be very few in number is clearly proved by the fact that the more thorough and complete is our aseptic technique the less is the morbidity. Further, the very remarkable gradual fall from year to year in the number of the morbidity cases at the Rotunda—as shown in the statistics I have quoted—is totally against the view that autoinfection is anything but a rarity in well-conducted maternities. It is a remarkable fact that puerperal infection (mortality or morbidity) is very uncommon among savage people, or among the patients confined on their way to a maternity; its risk seems to increase with the amount of interference, for in a maternity the morbidity is always less in those normally delivered than in those requiring assistance—a fact which shows how necessary it is, even in such institutions, to strive to improve the aseptic technique in operative cases.

The following statistics showing the mortality in England, Scotland, and Ireland, kindly supplied me by the Registrar-Generals of these countries, indicate that the puerperal infection is still a cause of many deaths—a fact all the more remarkable in face of the results in maternities, and when one considers how typhus fever, small-pox, enteric fever, and (outside Ireland) tuberculosis have all declined so markedly during the past quarter of a century:

DEATHS FROM PUERPERAL SEPSIS.

England and Wales.

Year.	Numbers.	Death-rate to a Million Females living.
1901	2,079	122
1902	2,003	118
1903	1,668	97
1904	1,654	94
1905	1,734	98
1906	1,640	93
1907	1,465	81

In England and Wales the numbers were for the year 1884, 2,580, being a death-rate of 186 per million females living.

Scotland.

	1904.	1905.	1906.
Puerperal septicaemia, sapraemia ...	113	124	123
Puerperal pyaemia	2	5	10
Puerperal fever (not otherwise defined)*...	126	119	130
Total	241	248	263

*Including puerperal fever, puerperal peritonitis, puerperal perimetritis, puerperal endometritis, puerperal phlebitis, etc.

The statistics for 1907 are not yet available. In 1884 the deaths from "puerperal fever" were 336.

Ireland.

The death-rate represented by deaths from puerperal septic diseases in Ireland during the year 1905 was 2.21 per 1,000 births registered; during 1906 it was 2.26; and during the year 1907 the rate was 1.60 per 1,000 births registered. In 1884 the deaths from puerperal fever and phlegmasia dolens represented a rate of 2.57 per 1,000 of all births registered in that year.

(B) *Operative Midwifery.*

During the last quarter of a century the employment of antisepsis and asepsis and the experience derived from abdominal surgery, due so largely to gynaecologists, have exercised a marked influence upon operative midwifery. This is well seen in our present knowledge of the pathology and treatment of extrauterine pregnancy, in the revival of symphysiotomy and its more recent modification, pubiotomy (hebosteotomy), in the thorough establishment of abdominal Caesarean section as one of the best major

operations (provided that there has been no previous risk of vaginal infection), and in the introduction of the vaginal Caesarean section, which, in the opinion of many, will be the method for promptly emptying the uterus in cases in which the cervical canal is intact. The treatment of contracted pelvis has been placed on a more scientific basis by recollecting that in every case of deformity of the bony parts we must rely both on pelvimetry, and on the relative size and consistency of the fetal head and its relation to the maternal pelvis.

The whole tendency of our operative measures now is to avoid craniotomy in a living child, and in contracted pelves to employ only those methods which are likely to save both mother and child. In pelves with a true conjugate below 3 or above 3¾ in., the line of treatment is clear, as in the latter we hope for spontaneous delivery, or delivery by aid of the forceps, while, in the former, Caesarean section or pubiotomy may be done. In the alternative of Caesarean section, asepsis is absolutely essential, while pubiotomy may be selected provided there are no evident signs of previous infection. Bumm[9] does this operation in cases of contracted pelvis where the true conjugate is not less than 6.75 c.m. ($2\frac{7}{10}$ in.), or in the cases of normal pelvis with an unusually large fetus. Most operators would, however, prefer not to perform pubiotomy if there were signs of infection, but this is a debatable question, as Zweifel thinks subcutaneous pubiotomy may be carried out even in cases with fever. In the intermediate group—that is, those in which there is a true conjugate of 3 to 3¾ in., every case must be considered on its own merits. One of the most interesting and important lessons we have learned in maternities in recent times is the occurrence of spontaneous delivery in many patients with contracted pelves. My own observation has taught me more and more that in a maternity hospital—where we can get rid of the importunities of the patients' friends educated in the former too frequent practice of early interference, and where we have an opportunity of observing Nature's own methods unobscured and not interfered with by unnecessary operative procedure—far more cases will terminate spontaneously under such conditions than one would suppose. Dr. Munro Kerr has had the same experience in the Glasgow Maternity Hospital,[10] as well as Zweifel at Leipzig; while quite recently Professor Schauta has shown that in his great clinic at Vienna[11] actually about 80 per cent. of the births with narrow pelvis occur spontaneously, only full-term births being considered. But we have learnt something more, and that is that spontaneous delivery in contracted pelves is by far the best method, both as regards the mother and the child. Not only are the soft parts of the mother not injured under these circumstances, but the child's head is not compressed; and, as Professor Schauta puts it: "Of all the possible methods of treatment of labour in contracted pelvis, the expectant treatment gives by far the best results for the mother as regards both mortality and morbidity. And I would mention here that we consider the puerperium disturbed if the temperature has once risen to 38° C. (100.4° F.). Regarding the child, we have also obtained the best results from spontaneous birth in preference to all other methods of treatment with the exception of Caesarean section."

In other cases (with a conjugate between 3 in. and 3¾ in.) of what has been styled the "medium degrees of pelvic deformity," where spontaneous delivery does not occur, the careful use of the axis-traction forceps applied in the dorsal posture to the sides of the child's head, which must be fixed, and with the patient placed subsequently in the Walcher position, gives better results, in my experience, than version; and, in case of failure, can be aided (so long as the child is alive) by dividing the pelvic bony girdle. The induction of premature labour in contracted pelvis is an operation I dislike, owing to the poor results as far as the children are concerned, the uncertainty of any of the methods employed, and owing to the fact that spontaneous delivery does not by any means follow in all cases. It is, in my opinion, much wiser in these intermediate cases of pelvic contraction, or in what are called "border line" cases, in which you cannot predict the outcome of the labour, to allow the patients to go to full term, as by this means now and again a patient will deliver herself, or, if the head becomes fixed, forceps may succeed, while, if after some hours of strong pains the head will not engage, then pubiotomy should be done as affording the best chance of the birth of a living child (provided a very careful consideration of the progress of the case has shown that the child is viable and that less dangerous methods are inapplicable), or Caesarean section, in case the fetal head is large and hard, the labour pains not strong, and the patient not infected. In multiparae, where there is a history that Nature failed to make the head engage in a previous labour, then Caesarean section, performed at the end of pregnancy or at the very onset of labour, is indicated. Let me emphasize the fact that, in all cases of moderate pelvic deformity, each must be considered on its own merits, and we must, in addition to measuring the pelvis, estimate carefully the relation of the child's head to the pelvic brim. Other factors in this problem are the skill of the obstetrician and his special experience in any particular method of delivery, and the question whether the deformity of the pelvis is recognized for the first time at labour, or, more fortunately, during pregnancy, and, finally, whether the patient is a primipara or multipara.

(C) *Complications of Labour.*

The scopolamine-morphine narcosis during labour, especially in nervous patients who bear pain badly, is of undoubted value, but, when used, mother and child must be watched closely; and, while in the main the treatment of *post-partum* haemorrhage is its prevention, we have now in hot water, the clearing out of anything from its cavity that may prevent contraction and retraction of the uterus, and gauze packing, good measures when this complication arises. Further, the management of the accompanying collapse has developed into a very hopeful scientific procedure. The treatment of pregnancy complicated with tumours—ovarian, fibroid, etc.—has been placed on much clearer lines, and, as a result, we know also more of the influence which pregnancy exerts on them, as, for example, the red degeneration of fibroids. In Ireland we think the method of plugging in accidental haemorrhage, and the use of morphine—combined with washing out the stomach, purgation, the lateral position, saline infusion, and delivery of the child as soon as the os is sufficiently dilated—in eclampsia give the best results. In placenta praevia, bipolar version followed by a natural delivery, and the use of Champetier de Ribes's bag, still constitute the alternative methods employed, though the results at the Amsterdam clinic obtained by Bonnaire's method of bimanual dilatation and extraction are very extraordinary.

Lastly, the treatment of rupture of the uterus by delivery of the child, manual removal of the placenta, followed by loose plugging and draining the tear with a large piece of iodoform gauze, has in many cases simplified the management of this serious accident.

II. THE FUTURE DEVELOPMENTS OF OBSTETRICS.

In considering the second portion of this address—the future developments of obstetric medicine—I would venture to suggest that the lines of advance along which we may hope for still further progress in the future will be (1) the more thorough practical training of students and midwives; (2) the public health aspect of obstetrics; and (3) the more intimate association with the practical obstetrician, of the physiological chemist, and of the clinical pathologist.

(1) *Need for More Practical Teaching of Students and Pupil Midwives.*

In bringing before you the present position of obstetric medicine, it must be clearly understood that the splendid progress I have tried to describe has been achieved in connexion with maternity hospitals, and that if we are to continue to make headway there, or to come up to the standard of these institutions in private practice, the students of to-day—who will be the practitioners of the future—must be trained as thoroughly in lying-in institutions as they now are in the surgical and medical wards of our large general hospitals. Now, students being, after all, only human, will simply fulfil (owing to the multitude of their studies) those conditions prescribed by the universities and licensing bodies. It is therefore incumbent on these authorities to make further and more stringent regulations for the attendance of students on practical midwifery. It is satisfactory to note that the General Medical Council has been moving in this matter of the clinical teaching of

midwifery, and, in answering a series of questions sent down in 1905 to the various teaching bodies by the Students' Practical Midwifery Committee of the General Medical Council, I made the following

*Suggestions for the better Training of Students in Practical Midwifery.**

They are based on my experience as a professor, clinical teacher, and examiner.

1. I think no student should be allowed to begin his attendance on cases until he has had a course of six months' systematic lectures. This would ensure that he has gained, at least, some knowledge of the theory of the subject. Further, no student should, in my opinion, be allowed to take out the class of systematic midwifery until he has passed all the previous—what may be termed "non-final"—examinations of the university or examining board whose degree or diploma he is aiming at obtaining. An example will make my meaning clearer: In the Royal University of Ireland a student, before the final degree (M.B.) examination, must pass three preliminary university examinations. The third examination in medicine consists of the following subjects: Anatomy, physiology, materia medica (with pharmacology and therapeutics). Now, I hold all students should be obliged to pass this examination before attending lectures on midwifery. It often happens they do not follow this course, with the natural result that while attending midwifery lectures their mind is all the time dwelling on this third examination which they have to pass, and so they do not take sufficient interest in the lectures, with the result that they begin their practical midwifery afterwards with a very inadequate knowledge of the theory of the subject.

2. I think a student should have taken out his pathology course before attending his labour cases, owing to the important bearing of pathology on many obstetric problems.

3. Students should, in my opinion, be required to give evidence that they have received clinical instruction in midwifery. The examining boards should not be content with simply a number of cases "personally attended," which too often means that the attendance is only during the labour. Evidence should be required that students have seen their cases regularly under the personal supervision of the obstetric physician for at least ten days after the confinement. In other words, midwifery should, like medicine and surgery, be taught clinically. At present the difficulty obstetric teachers have to meet is that students shirk the after-attendance on their midwifery cases, on the ground that they have so many other hospitals to attend (special and general). To obviate this they should be obliged to take their midwifery cases at a time when they can properly attend them, both at delivery and afterwards. A better knowledge of pregnancy from the clinical standpoint is also needed.

4. The number of cases of "personal attendance" should be at least ten, conducted by each student, and seen regularly for at least ten days afterwards.

5. No student should attend a case until he has seen, under adequate supervision, five cases, and while doing this his attention should be specially directed to acquiring a knowledge of the practical application of asepsis and antisepsis to labour, and of the importance of abdominal palpation as a means of diagnosis.

6. Each student should be drilled on the phantom in the technique of obstetrical operations—that is, he should personally perform such operations as forceps, turning, etc., under the direct supervision of a medical tutor.

7. In universities or examining boards of colleges, where at the Final M.B. degree, or diploma examination in obstetric medicine, students are examined in midwifery, gynaecology, and diseases of children, the candidates should be obliged to give evidence beforehand (in addition to the certificates in reference to practical midwifery) that they have also studied diseases of women and of children clinically. In other words, students should be obliged to show that they have had personal charge of cases (say six each) of diseases of women and children, either in the special wards devoted to these maladies in a general hospital, or in special hospitals for diseases of women and of children.

In the curriculum of the new Queen's University of Belfast it has been decided that every student before commencing the study of practical midwifery shall be required to have held the offices of a clinical medical clerk and surgical dresser, and to have attended a course of lectures on pathology, surgery, and midwifery. We have also adopted the suggestions of the General Medical Council passed in 1907, as follows, in regard to practical midwifery:

Every student shall be required either—

(*a*) To have regularly attended the indoor practice of a lying-in hospital or the lying-in wards of a general hospital for a period of three months; and after having received therein practical instruction in the conduct of labour, under the personal supervision of a medical officer, to have conducted twenty cases of labour under official medical supervision; or

(*b*) To have conducted not less than twenty cases of labour, subject to the following conditions:

That he has during one month given regular daily attendance upon the indoor practice of a lying-in hospital, or the lying-in wards of a general hospital or Poor Law infirmary, having a resident medical officer recognized for that purpose by the university; and that he has therein conducted cases of labour under the personal supervision of a medical officer of the hospital, who shall, when satisfied of the student's competence, authorize him to conduct outdoor cases under official medical supervision.

No certificate that the student has conducted the above-mentioned twenty cases of labour shall be accepted unless it is given by a member of the staff of a lying-in hospital, or of the maternity charity of a general hospital, or of a dispensary having an obstetric staff recognized for that purpose by the university, or of a Poor Law infirmary having a resident medical officer so recognized.

Every student before commencing the study of practical midwifery shall be required to have held the offices of clinical medical clerk and surgical dresser, and to have attended a course of lectures on surgery and midwifery.

Further, we have arranged that, in reference to gynaecology, every student shall present a certificate of having received clinical instruction in diseases of women, either in a special hospital for diseases of women recognized by the university, or in a special ward for diseases of women in a general hospital similarly recognized; and that, as regards diseases of children, every student shall present a certificate of having received clinical instruction in diseases of children for a period of three months, either in a children's hospital, or in a children's ward of a general hospital recognized by the university.

We have also decided to have a clinical examination in midwifery, gynaecology, and diseases of children.

With reference to the training of midwives, it would be a great gain if the Central Midwives Board would endeavour to raise the standard of general education among those applying to be examined by them, by demanding some test or certificate showing that the nurse had received a suitable general education (this standard could be easily arranged to suit each of the three kingdoms), and in every instance it should be obligatory that the nurses had enjoyed a surgical and medical training. A woman of good previous general education can be much easier taught a new subject, and can all the better appreciate the reasons for what she does in her special avocation, while an uneducated person is simply an automaton, doing what she sees others do, but without any real reason for the faith that is in her. Further, a previous experience in general medical and surgical nursing makes it so much easier to apply the principles of surgical cleanliness to midwifery. A course of training in practical midwifery for midwives should not be less than six months; indeed, its extension to one year would be better. I am confident that, by a more thorough practical training of students and pupil midwives, puerperal infection would show a much greater and more rapid diminution in private practice in the future; and, further, that owing to a more thorough clinical obstetric experience craniotomy on a living or dead child or decapitation would cease to be performed. We must teach our students how to recognize at the proper time—that is, during pregnancy, before labour sets in—that a woman has a contracted pelvis needing very careful obstetric treatment. We must impress upon students and pupil midwives that by early recognition and suitable treatment during pregnancy many otherwise serious complications may be warded off, and that even craniotomy on a dead child or decapitation might in most cases be avoided if a proper line of treatment was adopted at the beginning of labour, and that in the future pubiotomy or Caesarean section will take the place of craniotomy done on a living child. It is still, unfortunately, now and again an operation of absolute necessity, and unavoidable, as Professor Schauta has pointed out in opposition to the views of the Paris school, as put forward by Pinard, who teaches craniotomy should be entirely discarded. Schauta thinks it is "still indispensable in cases which reach expert aid too late, or in advanced stages of labour, often febrile from infection, where Caesarean section or hebotomy is contra-indicated, and in which, on account of the head being high above the brim, forceps cannot be applied, or on account of high degrees of stretching of the lower segment of the uterus turning cannot be performed, although the completion of labour is urgent."[12] We must in the future try to

* Report by the Students' Practical Midwifery Committee (of the General Medical Council) on the Operation of the Rules regarding Midwifery Practice required of Candidates for Medical Qualifications. May, 1906, p. 72.

get rid entirely of this horrid operation from obstetric practice by teaching students and midwives to recognize early the conditions calling for the newer operations, which will obviate the necessity for craniotomy. Further, we must in the case of the child—as in that of the mother—have regard both to its morbidity after birth as well as to its mortality, and a thorough consideration of what may be its subsequent condition after delivery should also enter into the problem of deciding the best way in which to help the mother.

(2) *Obstetric Medicine in Relation to Public Health.*

The modern obstetrician has two duties constantly impressed upon him—he must look after the interests of the mother, not merely in her hour of trial at childbirth, but also before and after that event, while, at the same time, he must care for the child. Now, in reference to the latter, he must concern himself not only with those factors that promote and favour antenatal life, but he must also have a thorough acquaintance with the means for preserving the life and promoting the growth and welfare of the newborn infant. The ideal we must all aim at in our practice, as I pointed out at the beginning of this address, is not alone the absence of *mortality*—that is, a living mother and a living child—but, at the same time, the avoidance of *morbidity*—that is, a healthy mother and a healthy child. If this ideal is to be realized it is absolutely essential—above and beyond the expert aid and advice afforded by the skilled obstetrician—that there should be spread more and more among the people the knowledge of motherhood. We must train the children in the public schools as to what is essential for the proper understanding of life, so that they may realize how often Browning's line is true:

Ignorance is not innocence but sin.[13]

Those who are brought face to face with the clamant public health problems of our great cities—and in the boroughs and urban districts of England and Wales there were 77 per cent. of the aggregate population in 1901 as compared with 50 per cent. in 1851—must feel that if we are to succeed in making a healthy nation, if we are to get rid of that physical degeneration which is so prevalent, and if we are to regain our ability and our energy—qualities which are so essential for any country in the present fierce struggle for existence, and so much of which has been lost through crime, ignorance, and apathy—we must cease to neglect the mothers of our people. No method will ever give us physical betterment which does not exercise a beneficial effect upon that sex which is the most dominant element in the development of the race. The more in every respect we elevate motherhood, the more we dignify home, and the more we raise our race.

Now, in order to spread the knowledge of what is really essential for good motherhood among the poor—especially of our crowded cities—we must insist that at the public schools the laws of health and hygiene are taught, and in connexion with these schools the establishment in Ireland recently of the Girls' Guild of Good Health (which is in affiliation with the Women's National Health Association of Ireland) is a distinct step in advance. The girls banded together in these guilds pledge themselves to be as healthy as possible in body and mind. We must also try to reach a class hitherto totally neglected—the poor expectant mothers—and to guide them in reference to such questions as food, occupation, housing, and temperance—factors so important not alone to themselves but to their unborn children, for it is well known that four-fifths of the value of an infant's start in life and its chance of living depend upon the proper nutrition of its mother during her pregnancy. Truer words were never uttered by any statesman than those spoken by the President of the Local Government Board, when, in a discussion in reference to the administration of his department in the House of Commons on June 17th of this year, he said: "It was the business of every employer of labour, of every husband and wife, and of every department and authority concerned in the future of the race, to see that the prenatal conditions of the child were vastly improved." In his interesting address last week at Leeds on Child Mortality in Relation to the Health of the State, Dr. Newman, Medical Officer of the Board of Education in England, said future measures of preventive medicine must start from the child and must deal with the home. Now, while both these means are admirable, unless the antenatal conditions are improved, even these efforts, good as they are, will, in many cases, come too late. Such aid, in addition to useful hints on various points, might in some cases take the form of good nourishment, especially during the latter half of gestation, outfits ("maternity bags") etc., for those who do not enter lying-in hospitals. In some places this help can be (and indeed is) afforded through voluntary philanthropic agencies, such as guilds of lady visitors, mothers' welcomes, babies' clubs, Samaritan funds, and maternity nurses; but looking at the way France, with her low birth-rate (and we must not forget that in England and Wales only two children are now born against the three of thirty years ago), has been compelled to face the problem, it is a question whether optional powers (as in Mr. Robert Harcourt's Necessitous Mothers' Assistance Bill, introduced this session) should not be given to local authorities to levy a special rate for this purpose.

I have shown that in modern times properly conducted maternities have banished that great scourge formerly styled puerperal fever, and it is to the credit and glory of obstetric medicine that it was Pierre Budin, Professor of Midwifery in the University of Paris and Director of the Clinique Tarnier, who, in 1892, started a similar revolution in the interest of the newborn child by establishing the first fully developed "Consultation for Nurslings," or School for Mothers. At a great congress of artisans in Paris in 1892, Budin said: "Your country has need of all her children, and humanity demands that we should spare no effort on their behalf." Shall we not repeat these words in every part of our empire? Here in Belfast we are making a beginning, for in connexion with the Infant Mortality Committee of the Belfast Branch of the Women's National Health Association of Ireland, that splendid organization established by Her Excellency the Countess of Aberdeen, whose magnificent work on behalf of public health in Ireland is known all the world over, there has been started a series of schools for mothers, called "babies' clubs." They now number four, situated in different parts of the city, and they are the first of the kind in Ireland, and are doing an immense amount of educative work in spreading the light in regard to good motherhood and in solving the infantile mortality problem. These admirable organizations are in close touch with the Belfast Maternity, the two children's hospitals, the dispensary midwives, the St. Vincent de Paul Society, the Nurses of Charity, and numerous other philanthropic societies of our city. They are managed by a small band of most devoted ladies, whose great aim is to afford practical help to poor, necessitous, and inexperienced women, and to bring before them the knowledge necessary for good motherhood. They show them how properly and hygienically to bathe, clothe, and dress babies, and how to laundry their garments. They encourage in every possible way the mothers to nurse their children, but in case of insufficiency or of total failure in this respect they supply them with milk which comes from a dairy where, by the tuberculin test, cows suffering from tuberculosis are excluded, where modern clean Danish methods are used with rapid cooling of the milk, which is placed in sealed bottles. This milk, following the method of the famous Copenhagen Milk Supply Company, is neither pasteurized nor sterilized, and by an arrangement with the proprietor of the dairy it is sent direct to the homes of the women whose children, in the opinion of the lady doctors who attend the clubs, really require it; but this milk is given only on condition that the infants are brought every week to the clubs so that it may be judged how they are progressing. These babies' clubs are thus doing a threefold duty: (1) They are educating the mothers; (2) they are supplying, when needed, a pure milk; and (3) they are affording an object lesson, even before the passing of Mr. Burns's Milk and Dairies Bill, as to the production of a natural, clean, non-tuberculous milk. Since the opening of the first club in February, 1908, up to July 1st, 1909, 889 children have passed through these institutions, and 5,640 quarts of pure milk have been distributed. In the summer of last year—July, August, and September—I am informed, not a child receiving this milk died. To the young expectant mothers hints are given as to the care of themselves, and they are advised as to making provision for their confinement.

Further, from a public health point of view, the Midwives Act of 1902 should be made to apply to the whole of the United Kingdom, and not, as at present, to England alone. Ophthalmia neonatorum, a preventable malady, which is the cause of at least one-third of the cases of permanent and hopeless loss of vision in our blind institutions, should be constituted a notifiable disease; and provision should be made for the early removal of cases of puerperal infection among the poor to hospitals or institutions where the results of the latest scientific research can be made available, and effective treatment can be employed.

(3) *Problems still Unsettled, Requiring for their Solution the Combined Efforts of the Obstetrician, the Biochemist, and the Clinical Pathologist.*

We have accomplished much in the last quarter of a century, but there are still many questions in obstetrics that await solution. How little we yet know as to the real nature of menstruation! Is dysmenorrhoea a disease, or is it a symptom of many underlying conditions? What is its relation to sterility? What a field the diseases of pregnancy afford to the careful scientific investigator! We speak of the toxaemias of pregnancy, but what are these toxins and how and where are they elaborated? What are the factors in the production of herpes (hydroa) gestationis? What really is eclampsia? How does tubal pregnancy occur? What is the cause of chorion-epithelioma? How do diseases of the placenta arise? Why are women at childbirth so susceptible to bacterial infection? Why do the bacteria travel at one time along lymphatics, at another in the course of blood vessels? We know that puerperal infection is caused by micro-organisms, but how do these microbes become virulent and in what way do they lose their malignant influence? Has season, race, or the predisposition (lowered resistance to infection) of the individual attacked anything to do with their power? In other words, while we know a great deal about the seed we are still largely in the dark as to the soil. No doubt operative interference has accomplished much in puerperal infection, especially in cases of localized abscess, pus tubes, and intense peritonitis limited to the pelvic organs, and occasionally in ligation or excision of thrombosed veins in puerperal pyaemia (as has been done in infected thrombi in mastoid disease);[14] still, when severe puerperal infection is present, can we yet boast of having advanced much beyond the view of William Hunter, who said, "Treat these in what manner you will, at least three out of every four will die." Have our surgical measures accomplished much in the very severe types of puerperal infection? Speaking for myself, in the most fatal and formidable form of puerperal infection—that due to the *Streptococcus pyogenes*—I have seen little advantage so far from surgical interference. The serum treatment of puerperal infection has also been disappointing clinically; and, indeed, with the exception of the antidiphtheritic and the antitetanic serums, is the preparation of the various antibacterial serums based on exact scientific principles? Certainly no one should use an antibacterial serum "except where, as in the case of an antidiphtheric serum, the pathologist is prepared to give him definite information with respect to the amount of protective substances in the serum."[15] Is the future of these severe puerperal infection cases, so far as treatment is concerned, not with that school established by one who received his early education in Belfast, Sir Almroth Wright, and his pupils, whose work is revolutionizing every branch of medicine, and who from each case of puerperal infection may elaborate the proper vaccine-therapy?

CONCLUSION.

We must invoke in the future, more and more, the help of the physiological chemist and of the clinical pathologist in the clearing up of the many unsolved problems of obstetric medicine, and they must work hand in hand with the practical obstetrician. It is in the laboratory situated in the maternity hospital that investigators, I am convinced, will help the practical obstetrician to unravel in the years to come many of these mysteries that still confront us, but they must look at these problems both from the clinical as well as from the biochemical and from the pathological side, and, as a result of the combined efforts of all these workers, may we soon be able to say:

There's a fount about to stream,
There's a light about to gleam,
There's a warmth about to glow,
There's a flower about to blow,
There's a midnight darkness changing
Into gray.
Men of thought, and men of action,
Clear the way.

Once the welcome light has broken,
Who shall say
What the unimagined glories
Of the day—
What the evil that shall perish
In its ray?
Aid the dawning, tongue and pen;
Aid it, hopes of honest men!
Aid it, paper—aid it, type—
Aid it, for the hour is ripe,
And our earnest must not slacken
Into play.
Men of thought, and men of action,
Clear the way!

Lo! a cloud's about to vanish
From the day,
And a brazen wrong to crumble
Into clay.
Lo! the right's about to conquer;
Clear the way!
With that right shall many more
Enter smiling at the door.
With the giant Wrong shall fall
Many others, great and small,
That through ages long have held us
For their prey.
Men of thought, and men of action,
Clear the way![16]

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A PLEA FOR A RATIONAL PUERPERIUM.

*WITH A RECORD OF A HUNDRED CASES.**

BY F. W. N. HAULTAIN, M.D., F.R.C.P.ED.,

LECTURER ON MIDWIFERY AND DISEASES OF WOMEN, EDINBURGH SCHOOL OF MEDICINE, ETC.

FOR many years I have thought that the conduct of the puerperium simulated more that of the convalescence from a severe illness than the management of the sequel of a normal function. I never, however, felt in a position to justify an attempt to disturb a custom which has prevailed through tens of centuries, and which is surrounded by traditions and superstitions.

It was, therefore, with pleasure I read the interesting paper by Von Alvensleben on "Das Aufstehen der Wochnerinnen in der ersten Tagen der Wochenbetts," wherein he gives the statistics of 100 cases. I felt that from the satisfactory results he obtained I had at least some data to go upon, before flying in the face of popular prejudice and fashion, and determined to give a fair trial to what I considered a rational management of a physiological process. My statistics I now have the pleasure of bringing forward. The mode of management adopted was as follows:

The puerpera, if willing, was encouraged to sit up in bed to meals on the second day. As early as she felt inclined thereafter she was allowed to leave her bed and walk to the fireside, where she sat for an hour. On the following day this was repeated morning and evening. The next day two hours, morning and evening, were spent out of bed, the patient sitting and walking a little if she so

* Read at the Obstetrical Society Edinburgh.

desired. The fifth day after rising was practically spent out of bed with the exception of a few hours' rest in the afternoon, and on the tenth day the patient left the hospital. The number of cases who followed this line of treatment was 100, all of whom sat up in bed on the second day; 40 rose on the third day; 35 rose on the fourth day; 25 rose on the fifth day. Of the 100 cases, 47 were primiparae and 53 multiparae.

Each was carefully examined before leaving hospital, and as many as possible six weeks later.

The morbidity in these cases—that is, a temperature over 100° F. or pulse over 90 for twelve consecutive hours—was represented by three cases. Two developed infective temperatures on the third day. One of these left the hospital well on the sixteenth, the other on the twenty-eighth day. Pelvic examination on the day of leaving hospital (tenth to twelfth day) showed the pelvic organs to be normal, except in two cases, where a slight retroversion of the uterus was present. In one there was considerable varicosity of the veins of the legs, but the woman remarked that it was not nearly so bad as after previous confinements—this being her seventh.

All the cases examined six weeks and more after confinement showed involution to be thorough, and the position of the uterus normal, with the exception of two, being those previously noted as having retroversion.

It was most interesting to hear the uniformly eulogistic terms in which, without exception, the women described their so-called convalescence; while the favourable comparisons made by multiparae with their former confinements was most convincing. Many voluntarily expressed the opinion that they had never felt so well previously, and from the others when asked there was no dissentient voice.

Even with statistics such as these one must necessarily ask oneself the cogent question, Is there any advantage to be gained by such a radical change in the management of the puerperium? For a satisfactory answer one must consider the question from the two important aspects of the patient and the practitioner. If the puerperal woman prefers to be in bed, and feels weak and needy of rest, no one, in a supposed free country such as ours, would suggest otherwise. But there can be no gainsaying the fact that it is otherwise in the vast majority of instances. The healthy woman after her confinement feels, during a normal puerperium, that the compulsory lying in bed prescribed is irksome to a degree. This exists in all ranks of the social scale, and it seems to me to say a great deal for the amenability of the female that she has so long put up with her enforced invalidism. Indeed, one of the most favourable characteristics of the normal puerperium is the feeling of well-being enjoyed, and it seems hard, unless there are very special reasons, that the mother should be condemned to ten days—indeed, even to three weeks—absolute confinement to bed. If no such reasons are forthcoming, it savours more of punishment for becoming pregnant rather than a reward for replenishing the earth.

Given the fact, then, that a mother feels fit and able to rise, and is desirous of doing so, we have now to consider the management from a therapeutic aspect, and to do so it might be as well to view the puerperium from both a physiological and pathological standpoint.

In these relations the former is most important, as the puerperium must be recognized to be the sequel to a physiological process. If labour is not a disease, the puerperium cannot be considered a convalescence. It is merely the natural return of the parts connected with pregnancy to their normal condition, in which is mainly concerned the involution of the uterus and the readjustment of the pelvi-abdominal circulation.

The former is more or less a function *per se*, influenced, probably, to a greater or less extent by the latter, mainly due to the inherent faculties of retraction and contraction directed by nervous mechanism, which is chiefly sympathetic in nature. The latter (the pelvi-abdominal circulation), however, is more dependent on physical conditions, and it seems to me particularly on intrapressure.

Immediately after delivery, from the rapid diminution in the size of the uterus in a practically closed cavity (peritoneal), intra-abdominal pressure is at a low ebb, as evidenced by the more or less constant distension of the intestines at this time. In like manner the intra-abdominal and pelvic veins are much distended, as shown by the terribly free regurgitation of blood in *post-partum* haemorrhage when the uterine sinuses are not thoroughly closed.

The return of intra-abdominal pressure to its normal must be mainly brought about by the retractability of the abdominal muscles, which under the most adverse conditions occurs to a partial extent. This, it is natural to suppose, must be greatly stimulated by the voluntary contraction of these muscles, in a like manner as the involuntary contractions of the uterus increase retraction. By increased pressure, passive pelvic venous congestion will be relieved and the circulation accelerated. To this probably is due the origin of the time-honoured binder as a substitute for the atonic, relaxed abdominal muscles.

In the present day management of the puerperium by enforced absolute rest in the recumbent position the abdominal muscles are not stimulated to retraction, and remain more or less atonic; and women rely on the maintenance of abdominal pressure, and, what is of greater importance to them, the return of their figures, to the inconvenience of a binder pulled to the verge of their asphyxiation by the energies of a nurse, with a result which is, alas! but seldom successful. Surely a more rational and natural, not to say efficient, means would be the contraction of the abdominal muscles themselves through voluntary movements. In this way not only would the figure be more readily restored to its pristine elegance, but the intra-abdominal circulation accelerated, and the other sequelae of defective intra-abdominal pressure, such as constipation, diminished.

Considering the puerperium from a pathological point of view, one may say generally it is beset mainly by four varieties of complication:

1. Septic inflammation.
2. Uterine displacements.
3. Subinvolution.
4. Venous derangements.

The question naturally arises, Are any of these influenced deleteriously or otherwise by the assumption of the erect attitude and moderate exercise?

SEPSIS.

As regards septic inflammation, no one can for a moment maintain that the position of the puerpera can be a primary source of infection. On the other hand, after infection has occurred, it seems reasonable to suppose that the freer drainage of the genital tract acquired by the upright position must necessarily be of advantage in facilitating the escape of the infected lochia; this must also be further aided by the increased intra-abdominal pressure induced by muscular contraction of the abdomen. The erect position has by various writers been suggested as of value. Thus Rueff, in the *Expert Midwife*, 1634, writes:

> Let the child delivered woman be brought to her bed, then let her lie on her backe, let her stretch out her legs and hold them wide abroad so much as shall be convenient, the other part of her body being so upright that she may rather seem to sit than to lie down, because by that means if any superfluous matter doth remain it may more commodiously pass away.

There can be little doubt, physically speaking, that this is correct reasoning. If so, how much more satisfactory must the entire erect attitude be? In this connexion, I may state that several patients have, during their first day's exercise, expelled large clots, which, should the women have rested in the recumbent position, would probably have remained in the genital passages for an indefinite period as mediums of septic incubation.

INVOLUTION.

As regards the question of uterine involution, other conditions being normal, the position of the patient must influence it but slightly; even, however, in this respect it is only reasonable to suppose that the increased intra-abdominal pressure which results from the contraction of the abdominal muscles must act in a salutary manner, mainly by stimulating the intra-abdominal venous circulation, and thus preventing passive uterine congestion.

UTERINE DISPLACEMENT.

On first impressions one might be rather apt to suppose that, from the increased weight of the uterus, displace-

ments of the organ in a backward or downward direction would be predisposed to by the early adoption of the erect position; this, however, is not borne out by the clinical facts, in which it will be noted that it occurred in 2 per cent. On closer reasoning from a physical standpoint, the erect posture must, I think, be considered a distinct factor in the preservation of the normal forward position of the uterus, and infinitely superior to the recumbent dorsal position at present practised.

When lying on the back the weight of the enlarged uterus must tend to stretch the round ligaments, which are the main structures in securing the forward position of the fundus; it thus predisposes to retroversion, should they be atonic or relaxed. On the assumption of the erect position, intra-abdominal pressure must, on the other hand, tend to accentuate the normal forward inclination of the fundus by pressing it downwards towards the pubes, and traction on the round ligaments is avoided.

An extreme example of the benefit of the vertical position in this connexion I observed on a private patient who, after her first confinement, acquired a decided backward displacement, which gave rise to much trouble, and, owing to prolapse of the ovaries, was impossible to keep in position by vaginal supports. Fortunately, she became pregnant again, and, by rising on the third day after labour, the uterus was maintained in its normal position, with the result that she is now perfectly well, and freed from the discomforts of her previous displacement.

If we concede, as I feel we must from the facts before us, that the normal forward lie of the uterus is favoured by the erect position of the patient, it is absolutely unnecessary to argue that prolapse will equally be avoided, as the prime factor in the initial stage of downward displacement is retro-displacement, by which means the uterus is disposed in the axis of the outlet. This is quite in accordance with the clinical facts from the cases observed, as in none was there the slightest evidence of prolapse.

Venous Derangements.

Perhaps the complication, the result of early rising, most dreaded by the lay mind is sudden death, due to pulmonary thrombosis and embolism. That this rare complication should play such a prominent part in this connexion is easy to account for, for it is an accepted fact that the vast majority of instances of this dreadful calamity occur after the tenth day, when the puerpera, according to conventional custom, has either risen, or at least has been allowed to sit up in bed. In the same way, white leg and phlebitis are particularly prone to develop about this same time.

As is well known, the blood of the puerperal woman is highly fibrinous and coagulable, hence the liability of these complications. To prevent coagulation it would appear to me to be most essential that the rate of the venous circulation should be stimulated. This can be most readily acquired by muscular exertion; thus *a priori* one would expect that by exercising the limbs and at the same time increasing intra-abdominal pressure by contractions of the abdominal muscles, the tendency to dilatation of the veins and sluggishness of the circulation through them must be avoided, and the tendency to coagulation diminished.

Besides these major complications, the mere maintenance of complete rest must tend to muscular atony. As we all know, on first rising after from ten days to three weeks in bed, the puerpera stands and walks with difficulty, and has to undergo a continued convalescence before the normal tone of her muscles has been recovered. On rising on the third day, however, there is little loss of muscular power, standing and walking are easily and comfortably accomplished. In like manner, the figure is more effectually and rapidly restored by the voluntary action of the abdominal muscles than by the most strenuous efforts of the nurse in tightening the binder. Yet another and important complication is minimized, namely, constipation; this is but natural to expect from the increased intra-abdominal pressure by exercise of the abdominal muscles. Its diminution by the adoption of the methods suggested is one of the most striking advantages noted.

It is difficult to understand why woman has been condemned for thousands of years to so much enforced idleness. In consulting ancient literature there is no evidence that the prescription was founded on a physiological or even a physical basis. In primitive races immediate exercise was the usual custom, the woman, to cleanse herself, at once after the birth of the child plunged into the lake or stream near which the confinements were usually conducted.

In what might be termed "the religious epoch," when priests assigned to themselves the position of obstetrical specialists, this practice seems to have been discontinued, and woman subjected to the ordeal of purification, which varied in detail amongst different authorities, but mainly consisted in enforced solitude for from ten days to three weeks, which was chiefly spent in the recumbent posture, doubtless from want of anything better to do. From this probably arises the term "confinement," so generally used for the act of child-bearing. Throughout this epoch empiricism rather than physiology was the basis of obstetric management, and this was determined by the supposed mystical powers of the priesthood. The religious atmosphere which pervaded obstetric practice 3000 B.C. is most interesting, and deities presiding over labour were innumerable. Roman mythology is particularly resplendent in such, from Mena, the goddess of the monthly flow, to Diana Lucina, who presided over labours.

Cleanliness seems, however, to have been at the root of practice, as shown by the teaching of the ancient Egyptians, from which sprang that of the Israelites. Gradually, however, the priest and the physician became severed, till in the time of Hippocrates, 400 B.C., a new era may be said to have become developed, and a considerable advance was made in the conduct of labours, by science founded on a higher, that is to say, a physiological, basis.

The work of Hippocrates, associated with that of Celsus and Soranus, seems practically to have been continued without change through the Middle Ages, and it is not until the time of Ambroise Paré (1550) that any advance can be said to have been made. From that time to the present day obstetrics has flourished through the efforts of Chamberlen, Smellie, Levret, Simpson, and a host of others. All their energies seem, however, to have been directed to improvement associated with the actual delivery, little or no change having been suggested in the management of the puerperium. Probably this was due to the fact that it was founded upon the religious edicts—on the observance of cleanliness and necessary purifications. It has therefore remained in a realm of theory, and no practical change has been advocated. The puerpera still remains condemned to rest in solitude without any true explanation of its nature having been considered.

From time to time specifics of various kinds are recommended. Thus Mauriceau, in the *Accomplished Midwife*, 1673, suggests the application of "the skin of a black sheep flayed alive to be laid all over the belly and lie on for 4 or 5 hours. A remedy of much trouble, for there must always be a butcher ready for every woman that is laid, who must for that purpose be in the very chamber or at least in the house that so they may have the skin very hot."

In like manner the application of cataplasms over the "privites" are recommended in textbooks. One of these consisted of "2 ounces of oil of bitter almonds and 2 or 3 yolks and whites of new laid eggs stirred together till it becomes of the consistence of a poultiss, which being spread upon a cloth must be applied to the parts, and when she hath fully done cleansing herself—which is usually after the 18th or 20th day—a fomentation is recommended of a decoction of pomegranate peel, cyprus nuts, acorns, Provence roses and alum."

In a general *Treatise of Midwifery* by Deones, 1720, p. 263, the following occurs:

> She can't be kept too quiet, she must be on her back with her head a little raised. She must turn herself as seldom as possible; she must be kept so warm that she may be constantly in a breathing sweat, and must not trouble herself in family cares or news, and must talk little and see very little company.
>
> Nobody is permitted to enter a lady of Quality's chamber for the first 9 days, neither has she any other light but candle night or day, and in the last place let her not point foot to the ground till the tenth day.

Penal servitude such as the above is at the present day fortunately not general, although in many instances it still exists in a but slightly modified form. Doubtless the skin of a sheep flayed alive and aromatic poultices have had their

day and been discarded, but not so the isolation and its concomitants. This probably is the result of the blind acceptance of principles founded on religious belief.

And the question naturally arises, Is there more reason for the latter than the former? Are the fads of Mauriceau or Dionès any worse or based on any less secure foundation than the fetish of a despotic priesthood? Are we as a progressive profession blindly to accept the practice of the latter merely on account of its antiquity or its religious origin, without any investigation from a scientific aspect? Surely not! It is in this attitude I have ventured to bring this important subject before the society for discussion.

I know I am sailing in dangerous proximity to an explosive mine loaded with tradition, prejudice, and superstition, the products of an ancient mystic empiricism, and sentiment; but I feel if one's armour be truly tempered with the modern improvements of physical and physiological science and practical experience, its most violent explosion can only result in a passing noise.

Changes in ancient customs, like hereditary attributes, are difficult to vary, and must be slowly attempted. The profession and the public cannot be expected suddenly to alter the teachings of their childhood. The instant adoption of a reformation such as I propose cannot be expected. Like the breaking of morphine or other habits, it must be gradual; but I feel convinced, both from practical proof and scientific reasoning, that a great change is bound to come in our treatment of puerperal women. Unless there is valid reason founded on a scientific and practical basis, it seems to me unbefitting of a learned profession such as ours to condemn them to an enforced tedious convalescence, the whole object of which resolves itself into the maintenance of an ancient mystic custom of so-called "cleansing." Theoretically it rests only on precept founded on empiricism; practically it has no foundation whatever, so far as my experience shows. It is a subject the importance of which cannot be overestimated. It demands mature consideration from a rational aspect. I feel, therefore, that no apology is required for bringing it before the society for serious discussion.

Three Demonstrations

ON

CONGENITAL MALFORMATIONS OF PALATE, FACE, AND NECK.

GIVEN AT THE ROYAL COLLEGE OF SURGEONS, ENGLAND.

BY

PROFESSOR ARTHUR KEITH, M.D., F.R.C.S.ENG.,

CONSERVATOR OF THE MUSEUM.

I.

THE material which has gradually accumulated in the various metropolitan medical museums during the last hundred years affords the basis for a very complete study of the various forms of cleft found in the palate and upper lip of children at birth. While the specimens which are shown at these demonstrations are derived from the museum of this college, it has also been possible for me, thanks to the unfailing courtesy of those in charge of the medical schools of London, to have free access to the valuable material on the shelves of their museums. A classified list of the total number of specimens at my disposal is given in Table I. Museum specimens are not representative of the run of cases met with in practice; the slighter and, from a surgical point of view, the more interesting lesions are sparsely represented, whereas the more severe forms, often associated with other grave lesions, predominate.*

TABLE I.—*Classified List of Specimens showing Congenital Clefts of the Palate and Upper Lip in Metropolitan Medical Museums.*

	A.	B.	C.	Total.
1. Palate cleft into three parts	14	12	2	28
2. Palate cleft into two parts	3	12	2	17
3. Median cleft extending from the premaxilla to the uvula	4	3	7	14
4. Cleft of soft palate	3	0	0	3
5. Cleft of uvula	4	1	0	5
6. Cleft on both sides of premaxilla	1	0	0	1
7. Cleft limited to one side of premaxilla ...	1	0	1	2
8. Median cleft due to absence of premaxilla	1	2	4	7
9. Bilateral harelip	1	0	3	4
10. Unilateral harelip	0	6	0	6
11. Median harelip	—	—	—	0
	32	36	19	87

A. Specimens in the Museum of the Royal College of Surgeons of England.
B. Specimens in the museums of metropolitan medical schools.
C. Specimens of cleft palate in mammals other than man, chiefly in the Museum of the Royal College of Surgeons of England.

TRIPARTITE PALATE.

In this, which must be regarded as the most severe form, the three elementary parts of the palate are widely separated. In all cases the lesion is remarkably alike, a typical example being shown in Fig. 1. In the middle element from before backwards are to be recognized (1) the middle part of the upper lip; (2) the premaxillary part of the palate, carrying the incisive papilla, which is joined to the upper lip by a fraenum; (3) the lower border of the septum of the nose, which is wider, shallower, and longer than normal; (4) the varying number of dental sacs on the premaxilla: in 16 cases only the two middle incisors are carried; in 3 cases one lateral incisor as well as the two middle (as in the specimen shown in Fig. 1), and in 4 cases all four incisors. In no case did the premaxilla in these cases show a suture between the ectognathic and mesognathic parts. The nerves and vessels of this element are the naso-palatine. On each lateral or maxillary element three distinct areas can be recognized (Fig. 1): (1) the alveolar area on which may be seen an elevation over the sacs of the two milk molars, another over the canine and frequently a third, often on the margin of the cleft, over the lateral incisor (Fig. 1); (2) a plicate or rugose area marked by folds; (3) a smooth narrow marginal area (see Fig. 1). When the mucous membrane is removed, the maxillary or lateral element is seen to be supported by the superior maxilla and palate bones. The nerves and vessels of the maxillary elements are the descending palatine.

The Nature of the Lesion.

Seeing that fusion of the three elements to form the palate begins in the human embryo at the fifth week, a period at which the branchial arches are best marked, it is only natural that one should turn to fishes to find as a normal condition one comparable to that seen in the tripartite palate of the malformed child. Embryology, too, leaves us in no doubt as to the class of fishes in which the condition should occur; the more we know of the early development of the mammalian embryo, the more we become convinced that it has much in common with the Selachii or shark tribe. The tripartite palate is an arrest of development at a Selachian stage. In Fig. 2 is shown the mouth of the dogfish; what at first sight appears to be its upper lip is divided by two furrows—the olfactory or naso-buccal—into three parts, a mesial and two lateral. The part between the furrows represents the middle nasal process of human embryology—the process which gives rise to the nasal septum and premaxilla. The furrows which represent extensions of the nasal openings towards, or actually into, the buccal cavity of the shark, are divided by a fold from the middle process (see Fig. 2) into two functional parts—an upper, the anterior nares, by which water may enter the nasal

* In 555 cases at the clinic of von Bruns at Tübingen, Dr. Gustav Haug (*Beiträge fur klin. Chirurgie*, 1904, Bd. 44, p. 254) found that the tripartite palate occurred in 15 per cent. (against 38 per cent. in the London series), bipartite palate in 23 per cent. (against 22 in the London series), unilateral harelip with no cleft of the palate 40 per cent. (against 9 per cent. in the London series).

cavity, and a lower or posterior nares, by which the water may be drawn into the pharynx as that cavity expands during respiration. At first sight the comparison seems imperfect, for the nasal furrows of the shark appear to lie rather on what may be named its face and entirely in front of the teeth. But these teeth behind the furrows in the shark's mouth are carried not by the maxillae but by the palate bones—bones represented in the human skull by the vertical processes of the palatines—situated, as is the shark's, at the posterior nares. The premaxilla and the premaxillary part of the palate are absent in the shark, but there can be no doubt that the area of tissue lying between the nasal furrows represents the part which bears the premaxilla in higher vertebrates, and that in the course of evolution the roof of the mouth has been extended on to this area.

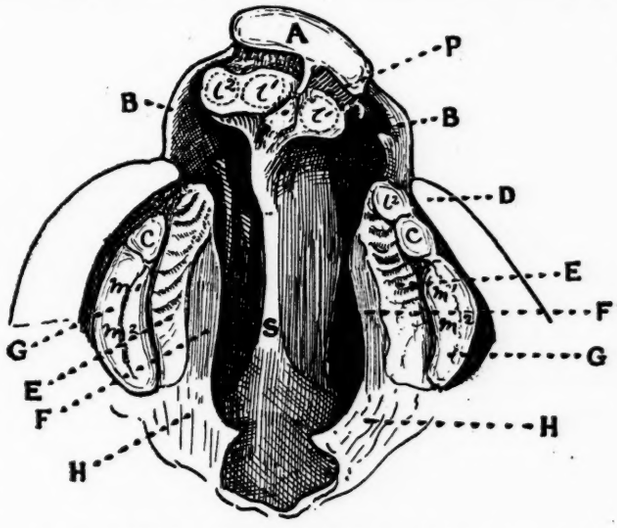

Fig. 1.—Tripartite palate. A, Median part of upper lip; B, C, alae of nose (two tags on left); C, canine tooth buds; D, lip; E, rugose part of palate; F, marginal part; G, alveolar part; H, soft palate with uvular process; I^1, I^2, incisors; P, incisive papilla; S, septum.

In those remarkable air-breathing fishes, the Dipnoi, the margins of the nasal furrows have actually fused. The bridge of tissue thus formed across the nasal furrows is the earliest form of union between the mesial and lateral elements of the palate. The condition of cleft palate, normal in the shark, has disappeared in the Dipnoi, and all vertebrates higher in the scale than fishes.

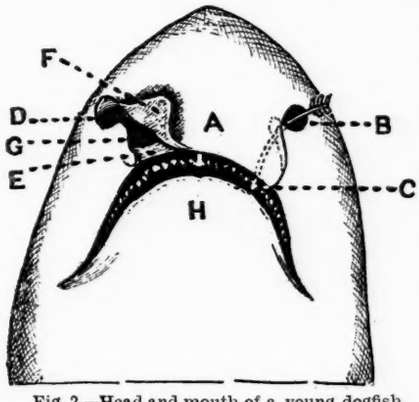

Fig. 2.—Head and mouth of a young dogfish (*Scyllium canicula*). A, Internasal field; B, anterior nares; C, posterior nares; D, anterior nares and olfactory pit; E, posterior nares; F, opercular fold (turned up), which separates the anterior nares from the posterior; G, maxillary process; H, lower jaw.

The stage of development seen in the Dipnoi may be studied more conveniently in amphibians. In Figs. 3 and 4 are shown side by side the palate of one of the larger frogs and of a lion cub—one of the many which have been born in the gardens of the Zoological Society of London with cleft palate. In the frog's palate a premaxilla has appeared, and it has extended across the nasal furrow and fused with the maxilla, so that a horseshoe-shaped alveolar arcade is now formed. The amphibian form marks a distinct stage in the evolution of the palate, and one at which development may be arrested, as shown by the specimen represented in Fig. 4. In the human embryo the Selachian stage is superseded by the amphibian during the fifth and sixth weeks of development; the mesial or premaxillary processes unite then with the lateral or maxillary element of the palate. During the seventh and eighth weeks the third or mammalian stage is entered on; from the lateral or maxillary elements two palatal processes grow out and fuse in the middle line, fusion commencing behind the premaxillary element and ending at the uvula (Fig. 4A). Within the palatal processes the horizontal plates of the maxillary and palate bones are developed. Arrest may occur at any point of the third stage. The development of the horizontal palate rendered the evolution of mammals possible; without such a palate suction and mastication are impossible, unless the breath be held while these acts are in progress.

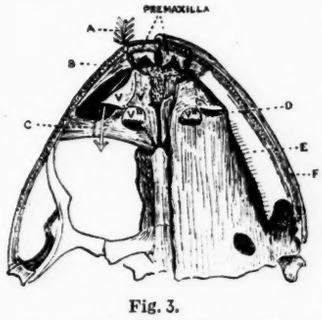

Fig. 3.

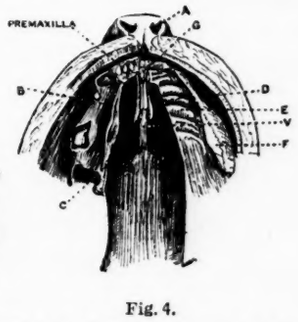

Fig. 4.

Fig. 3.—Palate of frog. Fig. 4.—Palate of lion cub with cleft palate. In both figures the mucous membrane is removed and the bones exposed on the right side. A, Anterior nares; B, palatal process of maxilla; C, palate bone; D, posterior nares; E, rugose part of maxillary palate; F, alveolar palate; G, incisive papilla with organ of Jacobson opening on each side of it; V, vomer; V', vomerine teeth.

The Degree of Separation between the Various Parts of the Palate.

The late Professor His was of opinion that clefts in the palate resulted from irregular and inco-ordinated growth of the three elements which go to form it. That the growth of the three parts is irregular in the later months of fetal life there can be no doubt (see Figs. 1 and 5). The septal part of the mesial nasal process is abnormally long, so that the premaxilla projects some 6 or 8 mm. in front of the maxillary parts of the palate. The increase in length of the septum is due not to the vomerine part of the septum, but to that part of it which is formed by the premaxillary processes (see Fig. 7). If the premaxilla becomes adherent to the maxilla on one side the extra growth of the septum still takes place, with the result that the premaxilla is bent towards the side on which union takes place (Fig. 5). Irregularity of growth is not the cause but the result of the cleft condition. From the evidence to be produced it is probable that the processes which form the palate were in contact during the fifth and sixth weeks of development, but for some reason—the exact cause we do not know—union did not take place then. The union of embryological processes is in every way comparable to the healing of wounds; the epithelial coverings on each side of the nasal groove come in contact and form a bridge across which the uniting mesoblast may grow. If for some reason union is delayed — and from Professor Mall's observations there can be no doubt that uterine inflammation, sometimes from syphilis, is the most common cause—growth in the several elements of the palate causes them to separate, and once a breach in their continuity has been effected, union cannot afterwards take place. The younger the fetus the smaller the cleft, not only absolutely but relatively. The width of the fissure between the palatal processes of the superior maxilla varies from 7 to 20 mm. in the tripartite palate; 14 mm. is the average in eight full-time children; in a fetus at the fourth month this cleft measured only 1 mm. Brophy[1] has suggested that the subsequent separation is caused by pressure of the lower jaw and tongue against the palate, and the material at my disposal is in harmony with his suggestion. He also makes the statement that there is

no atrophy of the parts that go to form the palate, but this is certainly not the case in the specimens I have examined. In three palates of adults the cleft was in the average 20 mm. wide, the breadth of the palate 64 mm.; the bony parts of these palates were thus 10 or 15 mm. less than normal. In newly-born children the deficiency affects the inner or marginal area of the palate (see Fig. 1), but it does not amount to more than 3 mm. on each side. Whether the cleft continues to increase after birth I am not in a position to say, but, judging from the width of the cleft in the adult palate, I conclude that the parts do not continue to separate after birth at the rate they did before birth.

Imperfect Degrees of Union.

In Fig. 5 there are shown very imperfect strands of union between the premaxillary and maxillary processes. A study of these throws much light on the condition of cleft palate. The slightest degree of union is shown in Fig. 5 A, where a strand of fibrous tissue covered by epithelium unites the ala of the nose to the premaxillary process; this represents the rudiment, or rather vestige, of the union of the mesial and lateral nasal process to form the boundary of the anterior nares. In B, C, D (Fig. 5) increasing degrees of union are shown. In the fullest degree (Fig. 5, D) the uniting band forms a bridge on which four elements end in attempting to reach the premaxillary process—(1) the ala of the nose, (2) the lateral part of the upper lip, (3) the dental groove, (4) the palatal process of the upper maxilla. These strands of union have apparently become stretched by the unequal or irregular growth of the parts which go to form the palate and upper lip; occasionally blunt conical processes occur on each side of the cleft, evidently the remnants of a strand which has broken under the strain.

The Relationship of the Incisor Teeth to the Clefts.

It is well known that the cleft usually lies between the middle and lateral incisors. In 41 cases I was able to verify the position of the fissure; in 23 it passed between the lateral and middle incisors; in 9 it passed between the lateral incisor and canine. In 7 cases the lateral incisor had not developed on the side of the fissure; in 2 cases a third incisor was developed. To explain the varying relationship of the fissure to the incisor teeth Albrecht supposed that the premaxilla was developed in two parts, that carrying the mesial incisor being developed in the mesial nasal process, and that carrying the lateral, in the lateral nasal process. Koelliker, and afterwards His, showed conclusively that Albrecht was wrong—that the lateral nasal process did not enter into the formation of either the palate or lip, but because Albrecht offered an explanation of appearances with which surgeons are familiar while the great anatomists offered none, his theory has been widely accepted in England. The true explanation of the varying relationship of the teeth to the fissure is extremely simple. The germ of the lateral incisor, although carried by the mesial nasal process, is laid down in the cleft between the maxillary and premaxillary (mesial nasal) processes. In cases of cleft palate the processes move apart under the strain of growth during the middle and later months of fetal life. Three fates may then overtake the bud of the lateral incisor: it may be destroyed, it may remain attached to the premaxillary process, but more frequently it moves outwards attached to the maxillary process. I have seen it stranded on the bridge of tissue between the processes or loosely attached at one side of the fissure or the other (see Fig. 5, c).

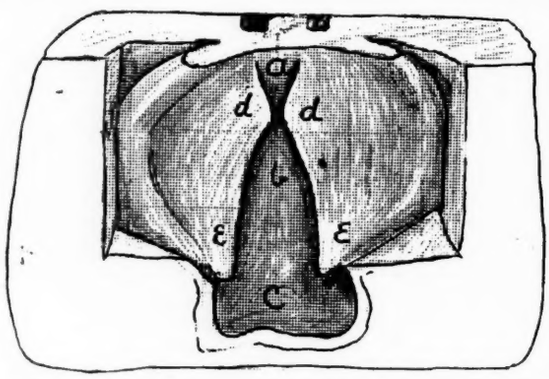

Fig. 4A.—Model of the developing palate of a human fetus about 6 weeks old (28 mm. long) (Anna Pölzl). *a*, Premaxillary part of palate; *b*, septum of nose; *c*, naso-pharynx; *d d*, maxillary plates about to meet; *e e*, soft palate and uvula.

Mr. Clement Lucas has pointed out that families in which harelip and cleft palate are hereditary have usually the lateral incisor of very small size; Professor Warnekros regards an irregularity in the development of the lateral incisor as the actual cause of cleft palate, and points out not only the frequent absence but the occasional duplication of this tooth in families in which cleft palate is apt to occur. Yet the bud of the lateral incisor belongs to and is developed in connexion with the mesial nasal process. In the condition of cyclops, where this process fails to take part in the formation of the palate, all the incisor teeth are absent.

Abnormalities in the Ossification of the Premaxilla.

Albrecht called attention to the fact that there is often a double centre of ossification in each premaxilla. (See Fig 6.) It will be observed that the amphibian premaxillae are subdivided (Fig. 3). The position of the suture between the premaxilla and maxilla and its relationship to the teeth are extremely variable. As a rule it ends between the lateral incisor and canine, but it may vary in position, as Schumacher has pointed out, to the degree illustrated in Fig. 7, ending in extreme cases either between the lateral and middle incisor or between the canine and first milk molar. The lateral part of the premaxilla is formed within the maxillary process; the process of ossification is not influenced by the position of embryonic fissure; the premaxilla is laid down in adjacent parts of all three processes that go to form the face.

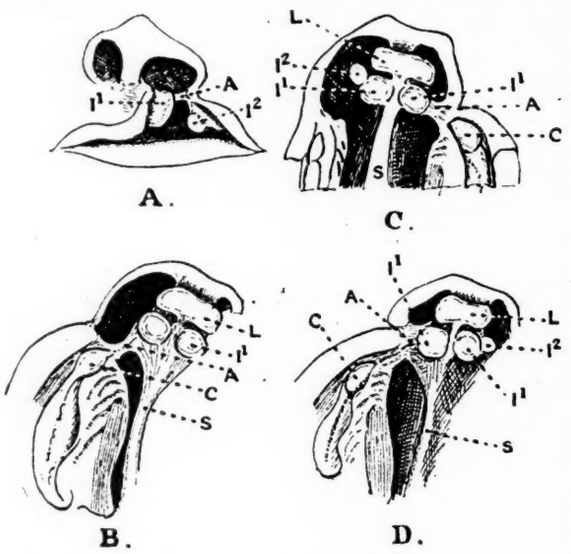

Fig. 5.—Four specimens of cleft palate showing various degrees in the development of the bond between the premaxillary, maxillary, and lateral nasal elements. A, The bond or bridge of tissue crossing the cleft; I^1, central incisor sac; I^2, lateral incisor sac; C, canine sac; L, median part of upper lip; S, septum of nose.

THE BIPARTITE PALATE.

Having discussed in some detail the tripartite palate it will be sufficient to deal with the less severe, if commoner, forms more briefly. In the bipartite palate the premaxillary element has undergone normal union on one side, usually the right, with the maxillary process (Fig. 7). Of the 15 cases in man, the cleft passed to the left side of the premaxilla in 11; Haug found it on the left side in 149 cases out of 216. Why the left side is the more frequently cleft I cannot say. The nasal septum in such cases is always markedly deformed, presenting its convexity to the side on which the cleft is situated. In 4 of these cases union had occurred not only between the premaxilla and maxilla, but also between the nasal septum and edge of the palatal processes of the maxilla and palate bone (see Fig. 7). In the usual form the lower border of the nasal septum is free, there being no union between the maxillary and mesial nasal elements.

Intermaxillary Clefts.

As we have seen, the union of the premaxillary element with the alveolar parts of the maxilla marks a distinct stage in the evolution of the palate—a stage well seen in amphibians. The next stage—the mammalian—lies in the development and union of the maxillary palatal processes already to be seen in the amphibian palate (Fig. 3). One would expect arrests to occur in the passage from the amphibian to the mammalian stage (see Fig. 3), although such specimens are comparatively rare in museums (of the 14 cases on my list, 7 are from the human subject, the others are from the dog, lion, sheep, and calf); they are the more common form of cleft palate met with in practice. Mr. J. Berry[2] records a list of 67 cases, of which 36 were due to non-fusion of the maxillary processes in the roof of the mouth. In these cases there is a real arrest, not only of the fusion of the processes, but of their actual growth. Clefts of the soft palate alone or of the uvula alone, as may be seen from Table I, are comparatively rare; I have seen 3 of the former and 5 of the latter. They indicate an arrest towards the end of the development of the palate when the fetus is about 50 mm. long and entering the third month of intrauterine life. Even when the palate is completely cleft the two halves of the uvula are clearly indicated as tags projected from the border of the palatal folds. The dissections in the College Museum show the tensor and levator palati well developed; the upper part of the superior constrictor and palato-pharyngeus are stronger than in normal palates.

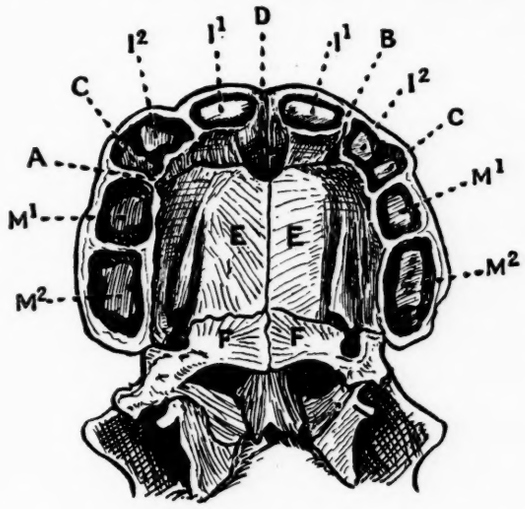

Fig. 6.—Palate of newly-born child (natural size) to show the elements entering into its formation. A, Suture between premaxilla and maxilla ending behind canine tooth; B, the same ending behind central incisor; C, canine; D, vomer appearing in naso-palatine fossa; E, marginal part of maxillary palate; F, horizontal process of palate bone.

Premaxillary Clefts.

The cleft or clefts may be limited to the premaxillary part of the palate. In the three cases included in Table I the fissure was unilateral in two cases and bilateral in the third. In these cases arrest had occurred during the period of formation of the primary palate, whereas the process of formation of the secondary palate had been successfully carried out. Besides lateral premaxillary clefts, there are two others, mesial in position, which are rare but worthy of notice. In one of these forms the embryological elements (the globular processes) which go to form the middle third of the upper lip and premaxillary palate have been arrested at an early stage, and a mesial cleft is thus left in the lip and palate. Of the 7 cases on my list 3 are from human subjects (see Fig. 8) and 4 from pigs. In such cases a lateral incisor may be present. The other form is very rare—namely, where a mesial cleft occurs in the upper lip similar to that which occurs in the hare. Cases of this cleft are described by Mr. Clutton and Mr. Edmund Owen in man. The two globular processes have not completely united together. This anomaly is much commoner in the domestic mammals than in man, as shown by the specimens in the College Museum.

THE CAUSATION OF HARELIP.

Although comparatively few family histories are at present available, there is a general agreement among those who have inquired into the matter that harelip and cleft palate are very apt to occur in certain families. Mr. Edmund Owen, Mr. Clement Lucas, and Professor Warnekros have recorded family trees showing the degree to which the condition may be inherited.* More suggestive of the true cause of the condition are (1) the malformation with which cleft palate is so often associated (spina bifida, anencephaly, morbus cordis, atresia ani, and club-foot); (2) the observations of experimental embryologists. Such malformations may be produced by disturbing the development of the embryo by various means, but one may conclude from Professor Mall's observations on malformed human embryos that morbid uterine or placental conditions are the commonest cause of malformation of the lip and palate in man. In a group of sixteen malformed human fetuses, the prevailing lesion being anencephaly, the following defects of the palate were found: Divided uvula 4, divided soft palate 1, division of hard and soft palates 1, anterior bilateral fissure 1, unilateral pre-maxillary fissure 1, bipartite palate 1, failure of ossification of hard palate 1. Eleven out of the sixteen showed malformation of the palate. These malformations are rarely met with amongst natives of Africa and of the South Sea Islands.†[3]

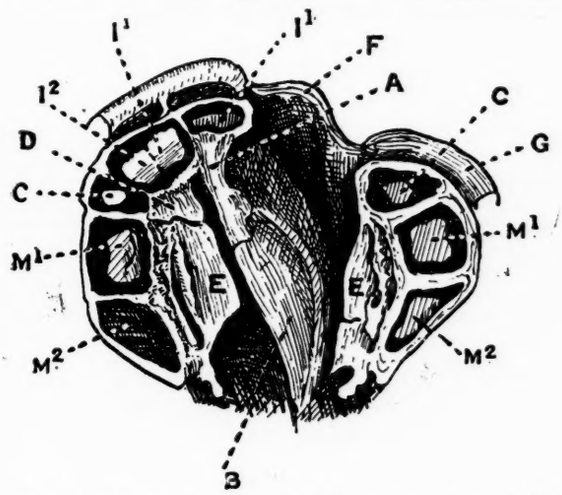

Fig. 7.—Bipartite palate. A, Septal process of premaxilla; B, vomer; C, canine; D, premaxilla; E, marginal part of palate; F, ala of nose; G, maxillary part of lip; I^1, I^2, incisor teeth; M^1, M^2, milk molars.

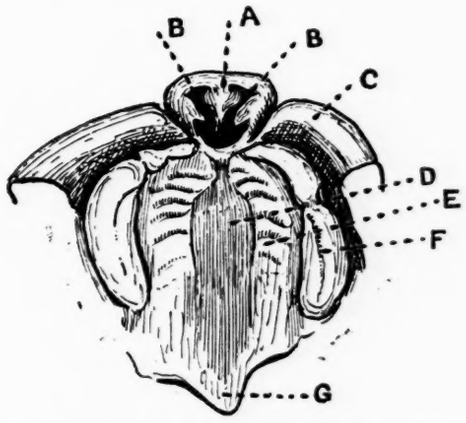

Fig. 8.—Absence of premaxillary part of palate (preparation No. 203). A, Vestige of septum and premaxillary process; B, B, anterior nares; C, lateral part of upper lip; D, marginal part of maxillary palate; E, F, rugose and alveolar parts; G, soft palate and uvula.

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* For details as regards heredity see Le Dentu. *Comptes rendus de l'Académie des Sciences*, 1908, t. 146, p. 1138.

† A skull of a South Sea Islander in the college collection shows a cleft of the palate.

TWO CASES OF HEAD-NODDING IN INFANTS.

By CAMERON GIBSON, M.A., M.B., CH.B.,
LATE HOUSE PHYSICIAN, EDINBURGH ROYAL INFIRMARY.

THIS disorder is, perhaps, of sufficient rarity to make the following notes of two cases worth recording.

CASE I.

Male child, 4 months old, brought on February 26th with complaint of nodding of the head and twitching of the eyes.

Parents are healthy and have had no nervous diseases. At birth the baby was healthy, but after the first week it was bottle-fed, and when seen at 1½ months old was very thin, shrivelled, and weak. There was no digestive disorder, but it was having a very weak milk and water mixture, and on the proportion of milk being raised it soon improved and put on flesh.

The head-nodding was first noticed at the beginning of February, the baby being then 3 months old; the twitching of the eyes was not noticed till one or two weeks later.

The child is now plump, but small and pale; when sitting and holding its head up, the head usually nods, with a monotonously regular forward and backward motion and very occasional jerk to the left side; sometimes the head is kept still for about half a minute, and it is usually still when leaning against some support, or when the gaze is fixed intently on some object. There is nystagmus in both eyes, but more in the right one; it is in a horizontal direction, and the optic axes remain parallel. Contrary to the nodding of the head, the nystagmus is much increased when the gaze is arrested by something bright. The mother says it is usually absent for a few minutes on waking after a good sleep; otherwise it is almost constant.

The mother complains that it cries a great deal, is frequently sick, and is constipated; it is fed at intervals of two hours, and has its milk "diluted" with strong barley water.

Two grains of phenazone were given daily, at first in ½-grain and later in 1-grain doses, and suitable alterations in the feeding were suggested.

March 22nd. Nystagmus much less; head-nodding quite as much as before, but now more horizontal and less in the sagittal direction. It cries very much less and is not sick.

There was no nystagmus noticed after April 4th, and no head-nodding after April 7th. When seen a week later there were no signs of any teeth coming through.

CASE II.

Female child, 18 months old, brought on March 23rd with complaint of nodding of the head and twitching of one eye.

The mother is epileptic; she is 29 years of age, and has had fits about once monthly for about eight years; her memory is considerably impaired. Father healthy.

The child has been previously healthy, except for some inflammatory condition of the left eye a few months ago, after which the twitching of the eye and head-nodding was noticed. The precise date of onset could not be ascertained, except that it was after Christmas.

The child is big and firm, walks well, and has no sign of rickets; it has all its teeth, except the back double ones. It has been breast-fed, but now has a mixed diet, and has no digestive trouble except constipation.

As a rule, her head is kept still; but occasionally, when she was sitting quietly on her mother's knee, it would nod in a horizontal direction, being pulled round more to the left than to the right side; this would last for half a minute and then stop. The eyes seem quite steady, but when the gaze is directed to the right there is nystagmus in the left eye in a horizontal direction. No nystagmus was observed in the right eye in any position.

Some treatment was directed to remedy the constipation, but none for the head-nodding.

A fortnight later the condition, especially the nodding of the head, was rather more marked, and in another fortnight it was practically the same, but the condition vanished about April 29th.

It was suggested by Henoch that the disease might be of reflex origin, a result of dentition, but neither of these cases lends any support to that view, as their cessation was not marked by any eruption of teeth and the first case was evidently not yet entering on the period, while the second was almost at its close. Rickets has also been suggested as a causative factor, but it was certainly absent in these cases. Raudnitz and J. Thomson have contended that it is due to the dim light in which these babies are living and trying to use their eyes, and this theory fits these two subjects well: the seasonal incidence, in the darkest months of the year; the environment—both these babies lived during the day in dark ground-floor rooms, with one window facing east, but shut out from most of the sky by tall buildings within a few yards, and neither baby was often in the open air. So far as one could find out the two had never been in contact, but their homes were less than 50 yards apart.

One could not be sure that the treatment by phenazone did anything to lessen the duration of the disease; from the time they came under observation both cases ran a course of between five and six weeks.

CLONIC SPASM OF THE DIAPHRAGM ASSOCIATED WITH A CERVICAL RIB.

By G. BERTRAM HUNT, M.D., B.S.,
SURGEON, SCARBOROUGH HOSPITAL.

I CAN find no case of clonic spasmodic contraction of the diaphragm recorded, except as part of the condition known as hiccough, from which this case differed, in that the glottis remained open during the spasm. Having the two very rare conditions of diaphragmatic spasm and a large palpable cervical rib coexisting in one patient, the probability that one condition stood in some relation to the other is very great indeed.

An anaemic, undersized girl of 16, markedly neurotic, first presented herself on account of a hard lump in the left posterior triangle of the neck, which she said had appeared lately. It was thought that this was probably a cervical rib, but, in the absence of an *x*-ray examination, an absolute diagnosis was not made. There were then neither pressure symptoms nor scoliosis, so that no operative treatment was recommended.

Three weeks later, following over-fatigue, the patient was seized suddenly one night with clonic spasm of the diaphragm—a sudden violent contraction, sometimes reduplicated, with each inspiration, exactly like hiccough, except that, owing to the absence of laryngeal spasm, there was not the characteristic "hic" sound of that condition. The spasm, which persisted day and night, was very severe—sufficiently so as to shake the bed in which the patient lay. It was practically uninfluenced by treatment—bromide, belladonna, chloral, even morphine under the skin, giving no, or merely transient, benefit. At the end of a fortnight the patient being in a miserable condition, apparently in danger of losing her life from weakness and loss of sleep if the spasm continued, it was decided to operate, the diagnosis being cervical rib causing irritative pressure on the phrenic nerve.

The lump was found to be a cervical rib running almost vertically downwards and forwards beneath, and parallel to, the inner border of the left trapezius. Across its anterior surface passed the cords of the brachial plexus, which were carefully separated and drawn aside. It was then possible, by working an elevator round the bone, to separate it from the dome of the pleura behind, and to remove the whole body of rib in its periosteum, about two inches in length, from its articulation with the transverse process of the seventh cervical vertebra above to its cartilaginous junction with the upper surface of the first rib below. The phrenic nerve was not recognized during the operation.

The patient made a good recovery. The spasm of the diaphragm ceased as she passed under the influence of ether, and has never returned during the two years that have elapsed since the operation.

There would appear to be two ways in which a cervical rib might cause diaphragmatic spasm: (1) By pressure on the vagus in the neck, causing a reflex contraction, much as derangement of the stomach may produce the ordinary hiccough by irritation of the terminations of the vagus in the gastric mucosa; or (2) by so exalting the normal impulse regularly passing down the phrenic nerve to produce the usual inspiratory contraction of the diaphragm by direct irritative pressure on that nerve trunk as to produce a violent spasmodic contraction of the muscle. The latter appears to me to be far the more probable explanation. The vagus in the carotid sheath lay some distance internal to the cervical rib, whereas the phrenic nerve in its course along the anterior surface of the scalenus anticus muscle must be exposed to pressure of a large cervical rib near the articulation with the scalene tubercle of the first rib.

The fact that removal of the rib, alone of the treatments tried, was directly followed by cessation of the spasm is another argument that this latter was probably caused by pressure of the rib, even remembering that *post hoc* is not always *propter hoc*, and that the administration of ether and the moral effect of the operation might conceivably have something to do with the cessation of the spasm. Whether the spasm was merely associated with the abnormal rib or whether the latter caused the former, as in all probability it did, this case, as far as I can trace the cases of cervical ribs in the *Index Medicus*, is unique. There are a number of cases of atrophy of the intrinsic muscles of the hand from pressure of a cervical rib on the

lowest cord of the brachial plexus recorded by Thorburn,[1] Lewis Jones,[2] and others. Keen[3] mentions that there are recorded four cases in which unequal pupil, unilateral sweating, or alteration in the palpebral fissure indicated pressure of an abnormal rib on the cervical sympathetic.

Cervical ribs may also press on the cutaneous branches of the cervical plexus, causing pains in the neck and shoulder; on the subclavian artery, causing either increased pulsation in the neck or impairment of circulation, even thrombosis or gangrene of the hand; or very rarely on the subclavian vein; but up till now the phrenic nerve seems to have escaped.

This case agrees with recorded experience that when symptoms are caused by the pressure of these ribs they are seldom noticed before puberty, probably owing to the ossification and increased rigidity of the ribs which then take place. Females are affected three times as often as males. It is noticeable that Russel[4] estimates that only 10 per cent. of those who have cervical ribs suffer from symptoms due to them.

With regard to removal of the offending rib, Keen[3] was able to collect, two years ago, 25 cases which had been operated on for the relief of various symptoms with no mortality.

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Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

RARE VARIETY OF FEMORAL HERNIA.

THE following case is an example of a rare form of femoral hernia in which the sac protrudes beneath Poupart's ligament, but external to the femoral vessels. The patient was a woman, 58 years of age, who had undergone an operation for femoral hernia in the right side three years previously. For six days there had been abdominal pain and vomiting, the symptoms commencing suddenly while she was at work in her garden; for two days there had been constipation which was not quite complete, as flatus had been passed, and repeated enemata had produced a slight result. When seen, the pulse was 112, temperature normal, the abdomen was distended and there was some general tenderness. Just below and parallel with Poupart's ligament on the right side there was an old scar, and at the outer extremity of this scar and just external to the femoral vessels a little thickening could be felt; this small thickening was not tender and the patient declared it had been present ever since the previous operation; there was no swelling in the situation of the femoral canal. Owing to the fatness of the patient, the presence of the old scar and the unusual situation of the slight swelling present, I found it difficult to decide whether the patient was suffering from a hernia strangulated in an abnormal situation, or from some other form of intestinal obstruction. I therefore opened the abdomen in the middle line below the umbilicus; distended small intestine at once presented, and a little examination proved that there was a Richter's hernia into a small hernial opening just external to the femoral artery. The gut was easily separated by a little traction and was found to be undamaged; the hernial sac would just admit the tip of the index finger, Poupart's ligament could be felt in front and the pulsations of the femoral artery just to the inner side; the femoral ring itself was firmly closed. Owing to the condition of the patient no radical cure was attempted. The usual textbooks contain no account of the rarer forms of femoral hernia. Tillmanns's *Surgery* mentions the variety I have described and also a form in which the sac is placed behind the femoral vessels. Hesselbach has recorded a case in which the hernia accompanied the anterior crural nerve.

I have drawn attention to this case because a hernia appearing in one of these abnormal situations is apt to escape notice and lead to a mistake in diagnosis.

EDMUND C. BEVERS, M.A., M.B., B.Ch.Oxon.,
Assistant Surgeon, Radcliffe Infirmary.
Oxford,
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A METHOD OF TEMPORARILY REMOVING COLOUR-BLINDNESS.

IN the *Practitioner* for October, 1908, I ventured to put forward a theory of colour-vision, and, consequently, one of colour-blindness.

My contention was that the cells of the retina move in one direction in response to a red stimulus, and in another direction to blue, while failure to move in any certain direction means failure to convey to the brain the result of a colour stimulus. This view I justified by some experiments I had done with electricity on sensitive photographic plates.

With regard to the sensation of white, I held that colour-blind persons respond to that sensation, because the total or complete movement of the cells is produced by a process of contiguity, which overcomes a sluggishness of response to any individual colour.

My theory, I venture to think, is the only one on which we can formulate any method of removing or temporarily improving this impediment of colour-blindness. Anything that would improve the movements of the cells ought to have the effect of stimulating the retinal cells to more ready response to colour sensations; and as the calcium salts have that stimulating effect on the body cells, I came to the conclusion that a big dose of calcium lactate ought to remove colour-blindness, if only temporarily.

The first case to undergo the experiment was a medical friend of mine, whose response to green sensations was nil, but who, after only 10 grains of calcium lactate, was able to appreciate and differentiate green-coloured articles. The appreciation in this person was certainly not complete, nor was I surprised that such was the case, for one could hardly expect that such a small dose would perform miracles.

In the next case I decided to give a greater quantity of the calcium salt, and for a longer period before the experimental test, and with this idea in view I arranged for the patient—a young man, aged 25—to call at my house at 2 o'clock, when I gave him 10 grains of the drug, and at 3 another 10 grains, and at 3.30 5 grains. At 4 o'clock I put him through a colour test and found that his response to all the colours was distinctly better.

The only objection to the experiment was that the patient had a headache for a few hours afterwards.

In the third case I gave only 20 grains, but the result was just as satisfactory and quite as conclusive.

Three cases are not sufficient to prove any theory, but they are sufficient to justify one in asking those who have greater opportunities for testing it to be so good as to do so.

G. ARBOUR STEPHENS, M.D., B.S., B.Sc.Lond.
Swansea.

Reports

ON

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

HAYWOOD HOSPITAL, BURSLEM.

THREE INTESTINAL OPERATIONS ON THE SAME PATIENT.

(By HAROLD HARTLEY, M.D.Lond., M.B., Ch.B.Manch., F.R.C.S.Eng., Surgeon to the Hospital.)

A MARRIED woman,* aged 34, was admitted on March 14th, 1907, suffering from strangulated and gangrenous right femoral hernia. Herniotomy was at once performed, but immediate resection with anastomosis was quite out of the question, as she seemed to be actually dying.

Although by vigorous restorative measures her general condition improved, it was some time before the desired passage of flatus and faeces was satisfactorily obtained. Then a free discharge of irritating, offensive, alkaline fluid began. Attempts to shield the skin were very unsuccessful. Sapraemia was marked and emaciation rapid. Neither a liquid nor a more solid diet, carbohydrates nor proteids, nor peptonization, made much difference to the discharge. Everything taken by the mouth appeared very quickly in a practically unchanged condition in the wound. Charcoal,

* This case formed the basis of a paper read before the Staffordshire Branch of the British Medical Association.

for example—given as a sandwich and without fluid—was seen on the thigh in ten minutes.

On March 27th the wound measured 4 in. by 2½ in., and was correspondingly deep; all gangrenous intestine and sloughs had been got rid of, but the skin around the wound, between the thighs, and on the vulva, buttocks, and lower abdomen was in a very bad state.

On March 28th enterectomy with end-to-end anastomosis of the bowel was performed. The abdomen was opened above Poupart's ligament, and the two coils of intestine passing to the artificial anus brought outside and packed off. Each was then divided between a pair of clamps down to the mesentery at about 2½ in. from the artificial anus. The ends of the two segments passing to the fistula were closed by purse-string catgut sutures reinforced by three Halsted sutures of fine silk for each end. End-to-end anastomosis over a Robson's bobbin next restored the continuity of the bowel—the first layer of suture being a continuous one of catgut through all the coats and the outer layer a continuous Lembert suture of fine silk—special attention being given to including both layers of the mesentery. The abdominal incision was closed by a single layer of silkworm gut sutures.

Progress after operation was all that could be expected, and on June 10th the patient went to Rhyl.

After a month she returned and asked to have the fistula removed, as each day about two ounces of irritating alkaline watery fluid with a little stringy mucus were discharged. Only one pocket could be found; it admitted the whole of my little finger, which was gripped by the external opening. On coughing, the pocket was seen to be slowly evaginated, and showed extremely lively peristalsis. It quickly partially strangled itself, becoming erect and bluish-black in colour, but this condition gradually passed away, and it withdrew inside again.

On July 12th, 1907, the intestinal pockets were excised through an abdominal incision made to the right of the original one. Numerous adhesions had been contracted by the pockets, one of which had become dilated by retained secretion owing to occlusion of its mouth by pressure of the other.

Recovery was excellent. She is able to work, and remains very well at the present time (July, 1909). A truss is worn, as the scars have yielded.

Reviews.

GYNAECOLOGY.

WE are all apt to lay more stress on pathology than on normal histology, and, though the latter is fairly well taught in medical schools, we tend to forget it; and, as in hospital and private practice we have more to do with diseased than with healthy tissues, we grow more and more liable as time goes on to mistake health for disease. This kind of error is no doubt frequent in gynaecology, which involves much inspection of doubtful morbid tissue, chronic inflammatory changes, new growths, and so forth. Hence this fine *Atlas der normalen Histologie der weiblichen Geschlechtsorgane* supplies a distinct want. Drs. MORALLER and HOEHL,[1] pupils of the late Professor W. His, senr., and of Professor Döderlein, to which distinguished authorities they dedicate their work, announce that it was prepared, on the recommendation of His and Max Sänger, to aid the practitioner in diagnosis, and to serve for clinical instruction. They have taken great pains to collect good material for their excellent original coloured microscopical drawings, in which they have had the aid of some of the most renowned gynaecologists and histologists in Germany and they gratefully acknowledge their indebtedness to Professor ROBERT MEYER, the director of a great obstetrical laboratory in Berlin, who has assisted them for ten years in preparing and collecting specimens. The prospectus published with this first portion of the Atlas gives a list of all the plates, including those to come, among which will be, we are glad to learn, some illustrations of the human ovary at all ages; we have been too much instructed from cats and guinea-pigs, where the ovary differs in many respects from that in our species. There will also be drawings of a series of sections illustrating the course of Gartner's duct—a disputed point. The authors, we may add, do not spell the Dane's name "Gaertner." The first fasciculus illustrates, by means of beautiful plates, the histology of the labium, clitoris, urethra and paraurethral ducts, hymen, Cowper's glands, vagina, and cervix uteri. The remaining plates, more beautifully prepared, if possible, than those just mentioned, are devoted to the muscular coat, endometrium, submucous tissue and subserous connective tissue of the body of the uterus. Lastly, though the cardboard outer cover is separate and made to close in the atlas by means of tapes, the paper cover, text, plates, and descriptive letterpress are stitched together, so that the atlas, 11½ in. by 8 in. in measurement, is far more convenient for study or reference than many of its colossal and clumsy predecessors.

[1] *Atlas der normalen Histologie der weiblichen Geschlechtsorgane.* Von Dr. Franz Moraller, dirig. Arzt der gynäk. Abteilung des St. Marienkrankenhauses in Berlin, und Dr. Erwin Hoehl, Nervenarzt in Chemnitz, unter Mitwirkung von Professor Dr. Robert Meyer, Vorstand des Laboratoriums der geburtshilflich-gynäkologischen Universitätsklinik der Charité in Berlin. Part I. Leipzig: J. A. Barth. 1909. (Demy 4to, pp. 87, 26 coloured plates with descriptive letterpress. M. 18.)

The title of the remarkable work by Mr. STEWART MCKAY of Sydney is somewhat misleading, as *Operations upon the Uterus, Perineum, and Round Ligaments*[2] suggests the inclusion of hysterectomy for cancer and fibroid disease, and for once it may be allowed that a longer title would have made the scope of the book more clear. Mr. Stewart McKay prefers to explain himself in an introduction. He mainly treats of the surgery of those immediate and remote lesions originating in injuries during the second stage of labour. He desires that the practitioner should know how to deal with primary lesions immediately after they have occurred, and how to understand and treat properly the results of neglect after these complications. He devotes one chapter, very properly, to anatomical points, discussing at length a very intricate subject. Without doubt, those who have the care of patients should understand this puzzling department of anatomy, and as far as good diagrams and drawings can serve, the author has done his best, but the anatomy of the pelvic floor and vulva is a ground of dispute amongst experts up to the present day. He makes clear the mechanism of perineal lacerations, warns the reader against false theories as to the supports of the uterus, and describes the scientific principles of perineorrhaphy. Then he devotes chapters to Lawson Tait's operation for ruptured perineum, to the surgical treatment of relaxed vaginal outlet, cystocele, rectocele, lacerated and hypertrophied cervix, and uterine displacements. Two other general subjects are included in this treatise—curettage of the uterus, and dysmenorrhoea. Mr. McKay is much to be commended for insisting that the use of the curette is a serious matter requiring foresight, skill, and careful after-treatment. We must congratulate the author on the excellence of his illustrations. The medical public have grown rather weary of diagrams, copied in textbook after textbook, intended to teach the reader how to repair a ruptured perineum. As a rule, the most youthful teacher of anatomy could justly criticize such drawings as far too small for their purpose. Mr. McKay has avoided these errors. His illustrations are all either absolutely original, or else drawn from Nature "after" some earlier authority. They are also big, properly lettered, and not overshaded. We include not only drawings of perineorrhaphy—a test subject—but all the other illustrations in the treatise. We know of no better drawing in any current works, even in the publications of the Johns Hopkins University, and Dr. Dupuy, the artist, deserves the praise justly awarded to him in the publishers' preface. Thus Mr. McKay has produced a work without dispute pre-eminent for the teaching value of its illustrations of plastic operations. The text also is distinguished for its clearness. Plastic operations on the vagina and perineum have to be done, and Mr. McKay teaches the reader how to do them so that they may prove successful. How far shortening of the round ligaments and suspension of the uterus should be taught to the inexperienced is, on the other hand, highly questionable. Mr. McKay is known as the author of *The*

[2] *Operations upon the Uterus, Perineum, and Round Ligaments.* By W. J. Stewart McKay, M.B., M.Ch., B.Sc., Senior Surgeon, Lewisham Hospital for Women and Children, Sydney, Member of the Royal Society of Medicine. London: Baillière, Tindall, and Cox. 1909 (Cr. 4to, pp. 471. Plates 148. 21s.)

Preparation and After-treatment of Section Cases, a publication which showed how thoroughly he understood the subject; he laid as much stress on after-results as on recovery from operation. In plastic surgery the patient should be insured, as far as art and science can be of any avail, against complications and bad after-results. We should have liked to have read more warnings of this kind than we find in Mr. McKay's newer work. Alexander's operation badly performed involves complications self-evident when we remember that the structures in relation to the inguinal canal are wounded, and that the uterine appendages may be diseased; the author warns the reader against the latter peril, but the beginner cannot always recognize pathological complications of this class. Nor are the inexperienced in a position to understand questions still disputed, such as ventrifixation and subsequent pregnancy, where the author disagrees with Herman and Giles. Still, as in the case of the far better established operations on the vagina, if suspension is to be done, it is best it should be done properly, and the author of course does his best in this respect. He is a safe and sure guide to the beginner who has to repair a perineum, and also to the experienced gynaecologist who has hitherto refrained from attempting those more questionable operations to which we have alluded, and who meditates their performance, not we trust until after much deliberation. No less experienced man should ever attempt them.

Dr. MEILHABER'S work on bleeding and discharge from the uterus is based upon original researches by himself and his assistants, which have been published from time to time in medical periodicals.[3] His main object is to elucidate the cases described under the names of "endometritis," "chronic metritis," and "chronic engorgement." In his preliminary remarks he calls attention to the great differences in the physical characters of the uterus at different periods of life, and to the differences in the uterine functions in different women. Just as among the millions of women who inhabit this earth no two are exactly alike in all respects, so with their uteri. Before making too much of what may seem to us a morbid condition we must know the patient's age, parity, menstrual habit, and the period of the menstrual cycle. Although Dr. Meilhaber urges the importance of taking these things into account, yet we cannot say he throws much further light upon what the normal changes in the uterus are. Dr. Meilhaber thinks that many investigators have confined their observations too much to the endometrium, and that the muscular wall of the uterus is as important as its mucous lining. Some thirty years ago Braxton Hicks read two papers before the Royal Society, in which he called attention to the effect of uterine contractions in helping the circulation through the uterus. Dr. Meilhaber appears to have rediscovered this, for there is no mention of Braxton Hicks either in his text or his bibliography. He devotes several pages to what he terms "*insufficientia uteri*"; that is, that the circulation through the uterus is not properly carried on because the uterine muscular tissue does not act properly. If the uterus is large, it is often because there is an excess of fibrous tissue, which hampers and hinders the muscular fibres from doing their duty. If the uterus is small, there may not be enough muscular tissue adequately to help on the circulation. If from either cause there is uterine insufficiency, then menstrual irregularities, haemorrhages, chronic metritis, chronic engorgement, etc., are the usual result. This is the chief novelty, or rather relative novelty, in Dr. Meilhaber's teaching. He describes carefully and well the treatment *quâ* haemorrhage, of the different kinds of disease that may cause excessive loss of blood; but his practice is not materially different from that which is taught in our London medical schools, except that he is a little more inclined to argue *post hoc ergo propter hoc* than some of our more critical English writers. Then he thinks Thure Brandt's massage of the uterus is good, because it stimulates uterine contraction. He states that he has sometimes obtained good results from Apostoli's electrical treatment. There is no doubt, he holds, that atmokausis (steaming the uterus) gives very good results as far as stopping bleeding. But there are possible after-effects: atresia of the canal, with haematometra—local peritonitis from the steam penetrating the uterine wall, or we presume the Fallopian tubes. The work is one of considerable interest. We confess ourselves to be much in Dr. Meilhaber's own position—we are unable to feel sure that we can correctly interpret his observations from the imperfection of our knowledge of the physiological changes in the uterus.

Dr. ALBERT BLAU, an assistant in the clinic of von Rosthorn at Vienna, has studied very thoroughly the questions concerning the origin and spread of tuberculosis in the female genital tract, and embodied his work in the form of a monograph on the subject.[4] He has read and summarized most of the recent German literature on the subject. He has not exhausted the literature, for he refers to nothing earlier than 1890, although there were persons who knew something about genital tuberculosis, and wrote excellent papers about it, before that date. He quotes a few French writers, and still fewer English, and the latter only through the medium of German abstracts. He has carried out a number of experiments in the Paltauf Institute for general and experimental pathology in Vienna. The whole investigation has been under the auspices of Professor Chrobak. He has analysed 36 cases of genital tuberculosis. In 25 of these 36 the adnexa were the seat of the disease; in 8 the adnexa and the uterus; in 3 the uterus only. The tubes only were diseased in 19 of the 25; in 6 the ovaries also. His general conclusions are as follows: In not one of his 36 cases could he find any evidence that the tuberculous infection had reached the uterus by way of the vagina. In guinea-pigs, animals peculiarly susceptible to puerperal infection, merely putting bits of tissue the subject of tubercle into the genital passage is not enough to infect the animal, unless it has been previously made specially susceptible either by parturition or by injury. He believes that the secretions of the female genitals are inimical to the tubercle bacillus, and that the epithelium of the female genital passage hinders the entry of the tubercle bacillus into the tissues. This, he thinks, explains why tuberculous disease of the genital organs is less common in women than in men, and in women less common than tuberculous disease of other parts of the body. In his view, such infection of the female genitals is only possible if susceptibility has been increased either by parturition or by some injurious influence; or if the tubercle bacillus is of an exceptionally virulent strain. These conclusions have at least this to recommend them: that they have been reached by much patient labour and study. English readers welcome the results of those who follow the precept of Harvey and seek out the secrets of Nature by way of experiment. But, unless the author can tell us how and why in a particular case the tubercle bacillus is an exceptionally virulent one, we have not advanced much by accepting his formula. His explanation remains a verbal one only. However, as countrymen of Harvey, we thank and praise Dr. Blau for his work.

Mr. BLAND-SUTTON and Dr. GILES'S well-known *Diseases of Women*[5] appears now no longer clad in the familiar pale-green buckram, but bound in elegant blue cloth. As before, the authors have taken great pains in the revision of their standard manual without making it bulky, physically or otherwise. All authorities and teachers will admit that they were judicious in extending their chapter on injuries of the uterus, for the curette is freely and widely used nowadays, and many employ it who would not undertake an abdominal section. One of the first duties of the teacher is to warn his pupil that "minor surgery" is never free from peril—a truth which the annals of gynaecology have amply demonstrated. The authors, too, were wise in laying more stress than before on the relation of the vermiform appendix to diseases of the female organs. Other additions involve matter which is open to

[3] *Blutungen und Ausfluss aus dem Uterus, ihre Ursachen und Behandlung.* Von Hofrat Dr. A. Meilhaber. Mit 9 Figuren im Text und 4 Tafeln. München: Ernst Reinhardt. 1909. (Roy. 8vo, pp. 87. M. 2.50.)

[4] *Uber die Enstehung und Verbreitung der Tuberkulose im Weiblichen Genitaltrakte.* Von Dr. Albert Blau, Assistenten der Klinik von Rosthorn in Wien. Aus der Klinik Chrobak in Wien. Berlin: S. Karger. 1909. (Roy. 8vo, pp. 95, 3 marks).

[5] *The Diseases of Women: A Handbook for Students and Practitioners.* By J. Bland-Sutton, F.R.C.S.Eng., Surgeon to the Middlesex Hospital and Senior Surgeon to the Chelsea Hospital for Women, and Arthur E. Giles, M.D., B.Sc.Lond., F.R.C.S.Edin., Surgeon to the Chelsea Hospital for Women, and Gynaecologist to the Tottenham Hospital. Sixth Edition, with 123 illustrations. London: Rebman, Limited. 1909. (Post 8vo, pp. 562; 123 illustrations. 11s.)

criticism. Mr. Bland-Sutton awards a chapter to fibrosis uteri, and states that he has removed the uterus sixty-seven times for fibrosis, and it is on that experience that the description of the disease given in this edition is based. The authors are quite right in teaching that adenomyoma of the uterus, to which they also grant a special chapter, is a grave malady, though histologically benign. The reviewer naturally turns to the paragraph on Wertheim's operation, to see what is taught about so radical a measure. We find it very clearly described, but feel that the authors are not enthusiastic about it. "The radical operation for cancer of the neck of the uterus," they declare, "is on its trial in Great Britain. The operative mortality is very high, and no reliable returns concerning the remote results are at present available." We quite agree as to the propriety of the new chapter on injuries to the ureter in pelvic operations, and understand perfectly why the authors take pains to show that it is a corollary of their views on Wertheim's teaching and practice. "Since the vulgarization of hysterectomy, and more especially in the operation of total hysterectomy, vaginal hysterectomy, and the so-called 'radical' operation for cancer of the neck of the uterus, the vesical segments of the ureters are very liable to suffer injury." No doubt "so-called" is rather cruel, but the opinions in a book meant to teach must be carefully expressed, and Wertheim's operation is a procedure to be learnt or rejected by the expert rather than to be taught to the pupil. In conclusion, we may repeat, for reasons which we have made clear, that the authors have taken great pains not only to bring the new edition up to date, but what is more important, to exercise judgement about new doctrines and methods.

We have already reviewed the three original German editions of the *Lehrbuch der gynäkologischen Diagnostik*, by WINTER and RUGE, and Dr. JOHN G. CLARK,[6] with the assistance of Dr. Max Goepp as the literary translator, has brought out an English version with the title, *Textbook of Gynecological Diagnosis*, after the best style familiar to us who read the products of the Johns Hopkins and other Transatlantic presses. Dr. Clark admits in his preface that, "although much has been established in the practice of gynaecology in the United States, we owe much, nevertheless, to English and Continental gynaecologists for the discovery and inauguration of many essentials in theory and practice." It is comforting to find that Old England is not always overlooked, and that Dr. Clark graciously mentions us in the preface to a translation of a work published in another European country. We must all agree with the translator's praise of German gynaecology in general and of this textbook in particular; indeed, neither needed an apology. There is a lamentable ignorance of the language of Goethe and Schiller in the United Kingdom, and its literary construction is somewhat intricate. This translation will therefore be of great value to those who are ignorant of German, as the pages on the diagnosis and physical signs of abdomino-pelvic tumours are highly instructive; moreover, they encourage the reader to study and examine every case under his care thoroughly rather than to begin what many are too ready to call "diagnosis" by opening the abdominal cavity. The pathological illustrations and text are also of great importance, owing to the high authority of their author, Carl Ruge, and the skill of his artistic assistants. The Briton should, therefore, be grateful to the translator who has enabled him to read the text in his own language.

The literature of the diseases of women has become voluminous, but Dr. GOTTSCHALK has prepared a manual which is to a certain degree original. *Gynäkologie*[7] is the eighteenth volume of Dr. Luithlen's *Medizinische Handbibliothek*; it is very handy and well condensed, contrasting with too many textbooks that are clumsy in form and irregularly elementary and advanced in text. Thus the letterpress is void of references, free from padding with elementary anatomy, and not cumbered with pathological subtleties, nor does the author overload his pages with details of the countless modifications of abdominal and plastic operations too often admitted into elementary and synoptic works. The handbook is mainly clinical, with concise accounts of therapeutic and surgical measures for the relief of diseases of the female organs. The illustrations are artistic and instructive.

Dr. CATHERINE MACFARLANE'S *Handbook of Gynecology for Nurses*[8] is a good synopsis of the anatomy, pathology, surgery, and therapeutics of the female genito-urinary tract, published in a convenient and portable form. The essential portion, however, is that which pertains to the duties of a nurse. The authoress lays stress on clothing, gauze, folding of pads and gauze-sponges, etc., as well as on the selection and sterilization of instruments for operations, and the directions for irrigation of various parts and cavities, and the preparation of enemata and saline transfusion are written in plain language and made more clear by illustrations. The modern nurse has a great deal to learn, and this work can teach her much and help her to remember what she has been taught already. It is free from many objectionable features familiar to us in publications of this class, and lacks nothing that is really necessary.

MEDICAL INSPECTION OF SCHOOLS.

IN Dr. HOGARTH'S *Medical Inspection of Schools* those interested or employed in the work of medical inspection in our public elementary schools will find much that is valuable.[9] The school doctors are greatly in need of such a lead as he gives, and without necessarily endorsing all his opinions, we may say that they will find information on many of the difficult questions which constantly crop up in connexion with their duties.

The aims and objects of medical inspection are clearly set forth, and many fallacies are exposed. The effect of routine inspection on outbreaks of epidemic disease, the seemingly normal child, the demand for statistics, exclusion of children from school, unsatisfactory school buildings, closing of schools for infectious disease, the extent of medical inspection of a child, the school nurse, the evolution of a school doctor, medical attendance on the poor, and public charities in connexion with school work, are only a few of the points on which Dr. Hogarth gives great help to the beginner and support to those with more experience. In other respects, however, neither the writer, nor as yet anyone else, can give reliable guidance. What is possible in London is not necessarily so elsewhere, and what works well in one city may not do so in another. Education authorities, and the representatives of ratepayers vary in their estimate of what is desirable. The effect on general practice which the appointment of general practitioners as school doctors would have, and the question of home visiting, are too airily dismissed. Many of Dr. Hogarth's suggestions as to what should be done with regard to medical inspection and how it should be done, are unfortunately, as yet, quite beyond the confines of practical politics, but, taken as a whole, they form in most respects an excellent ideal to aim at and work for. Perhaps it is unusual to consider the obstacles in the way of the school doctor taking an ideal place as an authority capable of, and with the right to dictate as to school curricula, but these exist. The experienced teacher, Government and local inspectors, educational experts and "interested persons" all exist, and each has as yet a stronger voice than most school doctors. The case for school dentistry, as of paramount importance does not seem convincing, and the provision of free dentistry at this juncture may handicap the general scheme heavily.

The suggestion that attendance at school clinics must be optional and free, is open to grave objection under both heads, though perhaps treatment would have to be technically optional.

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[6] *Textbook of Gynecological Diagnosis.* By Dr. Georg Winter, Königsberg, with the collaboration of Dr. Carl Ruge of Berlin. Edited by John G. Clark, M.D., Professor of Gynaecology, University of Pennsylvania. After the third revised German edition. Illustrated by 4 full-page plates and 346 text illustrations in black and colours Philadelphia and London: J. B. Lippincot Company. 1909. (Sup. roy. 8vo, pp. 690. 25s.)

[7] *Gynäkologie.* Von Professor Dr. Sigmund Gottschalk in Berlin. Vienna and Leipzig: Alfred Hölder. 1909. (Crown 8vo, pp. 370; 46 illustrations and 1 coloured drawing. M. 6.)

[8] *A Reference Handbook of Gynecology for Nurses.* By Catherine Macfarlane, M.D., Gynecologist to the Women's Hospital of Philadelphia. Philadelphia and London: W. B. Saunders Company. 1908. (Pott 8vo, pp. 150; 68 illustrations. 6s.)

[9] Oxford Medical Publications. *Medical Inspection of Schools.* By A. H. Hogarth, M.B., B.Ch.Oxon., D.P.H., M.O.H. for Buckinghamshire, Assistant Medical Officer (Education) London County Council. London: Henry Frowde, and Hodder and Stoughton. 1909. (Cr. 8vo, pp. 360. 6s.

The problem of the badly-nourished child, and the position and duty of the educational authority with regard to it, have not been seriously tackled yet—certainly not in London, and are peculiarly difficult. One would have wished for an extension of the chapter on diseases affecting school life, and some more useful information with regard to mental defectives. The treatment of stammering is not difficult, and in most cases is quite satisfactory, and should be included; respiratory exercises alone are not sufficient.

The specimen card for the record of medical inspection hardly seems adequate for the purposes which it has to fulfil, while that suggested by the Board of Education certainly contains more than can be made practical use of.

On reading the regulations as to exclusion of children from school for infectious diseases, one wonders how it is that medical officers of health differ so much on these points, and whether uniformity in similar districts is out of the question.

Dr. Hogarth's book, following as it does a somewhat similar work relating to the public schools in the United States, will place school medical officers in a much better position to look at the whole question from all sides and with adequate knowledge.

INTERNATIONAL CONGRESS ON ALCOHOLISM.

(*Continued from page 218.*)

Alcoholism in Hungarian Children.

Dr. Imre Doczi, of Budapest, the official representative of the Hungarian Parliament, read a paper on Alcohol and its Effects on Children. He said that in some communities children were given bread soaked in brandy, while in other instances brandy was given to stop them crying. Because of its extraordinary cheapness, brandy was often given to the children for breakfast. In consequence of the degenerating influence of alcohol the birth-rate in communities where these practices prevailed was becoming less every year. The opportunities for indulging in intoxicating liquors had grown to such an extent that pupils in the first and second elementary classes came to the schools quite intoxicated. Reports had been received of pupils being so intoxicated that they were unable to do their lessons. The influence of this juvenile drinking on mind and character was very marked; 36 per cent. of the children were found to be careless and idle, 11 per cent. dull of comprehension, 13 per cent. incapable of any prolonged attention. In other directions the effects were equally startling; 30 per cent. were inattentive, restless, and nervous, 15 per cent. melancholy and abnormally shy, 30 per cent. coarse and without any feeling, 9 per cent. vindictive and given to stealing, 18 per cent. immoral, while only 20 per cent. showed no apparent evil effects. Three-fourths of the children who indulged in alcohol were found to be of colourless complexion and pale, with sunken cheeks; one-fifth showed arrested development of the body; and in only one-fifth was the disturbing influence of alcohol unnoticed.

Alcohol and Home Life.

Mrs. Bramwell Booth, in a paper entitled "Alcohol in its Relation to the Home," pointed out that liquor not only dissipated the substance and material resources of the family, but opened the door to the most vicious forms of self-indulgence and impurity, and was the implacable enemy of all that belonged to the ethical advance of the community. Too often the children's milk was sacrificed to the father's beer, and that experience proved that alcohol was the natural ally and friend of the beast in man.

Juvenile Temperance and the National Life.

Miss Cora Stoddard, of Boston, U.S.A., read a paper in which she said that many employers of labour demanded total abstinence on the part of their employees. There were two million positions in the United States closed to men who were in the habit of using strong drink. The bankruptcy of nations was due less to the decline of trade or periodic waves of commercial depression than to their loss of moral ideals. It was in harmony with the spirit of medical and social science that preventive efforts should be put forth in time rather than that redemptive measures should be adopted when too late. An inquiry instituted in American institutions showed that two-thirds of the inebriates began to drink when under 16 years of age. A systematic course of temperance teaching would not only influence the nations of to-day, but its greatest effect would be seen in the nations of the future.

Mr. G. Sharples (Manchester), who represented the National Union of Teachers, said the Education Department had at last embodied in its regulations a permission to enclose the seed of temperance teaching in lessons on hygiene. He was sure there was not a school in this country where the effect of the syllabus would not be most beneficially felt, but in addition to the temperance teaching there was the personal factor of the teacher to be reckoned with, and a great step forward would be gained when the teachers were taught, as it was probable they would be in the new training colleges, the vicious effects of alcohol.

Alcohol and the National Services.

Referring to the navy, Vice-Admiral G. King-Hall said that 80 per cent. of the crimes against discipline, such as leave-breaking and insubordination, were due to excess in taking spirituous liquors. On the other hand, temperance improved the health and morals of the men, and gave clearer minds and a higher development of the powers of the intellect. There were now about 25,000 total abstainers belonging to the Royal Navy Temperance Society.

Colonel L. G. Fawkes said there had been a great improvement in the sobriety of the British army during the last twenty-five years. Twenty-five per cent. were now abstainers, and the non-abstainers drank half the amount formerly consumed.

An evening meeting in connexion with the Congress took the form of a demonstration of the temperance forces of the national services, the departments represented being the navy, army, postal service, the railways, and the nurses. The Lord Chief Justice, who presided, said that after forty years at the Bar and ten years as a judge he had no hesitation in saying that 90 per cent. of the crime of this country was caused by indulgence in strong drink. There was a custom prevalent in the Temple of giving drinks to both barristers, witnesses, and clerks on the completion of litigation cases. What was eminently desired was to promote among the young fellows in the Temple the manliness and courage which would enable them to resist the temptation to drink.

Miss Agnes Weston, who was escorted by a company of the Royal Naval Temperance Society, elicited great applause by the statement that the flags of two teetotal admirals were flying between London and the Nore, and if Admiral King-Hall's ship had been in commission there would have been a third.

The Hon. A. H. Holland-Hibbert, who spoke on behalf of the railway service, said that the membership of the London and North-Western Railway Society was increasing at the rate of 2,000 per year. He condemned the practice, happily declining, of railway passengers offering drink to guards and porters.

World-wide Prohibition.

A meeting was held at the Imperial Institute for the purpose of establishing a world-wide confederation in favour of prohibition.

Mr. E. P. Gaston, Honorary Secretary of the Provisional Committee, outlined the objects of the confederation. They had met to bring into closer touch with each other the many organizations which were endeavouring to put an end to the legalized liquor traffic throughout the world. Twenty-five to thirty countries were represented. The confederation was to be carried on by voluntary workers, who would collect and distribute information.

On the motion of Mr. Bruce Mickleham, the following resolution was carried unanimously:

> That the present is the opportune time for taking some steps which may better amalgamate the various forces working along their respective lines towards the common aim of the suppression of the drink traffic.

Mr. Guy Hayler and Mr. Gaston were then elected convener and secretary respectively, with power to elect a representative committee to draw up a constitution and make a report.

(*To be continued.*)

SEVENTY-SEVENTH ANNUAL MEETING

OF THE

British Medical Association.

Held at Belfast on July 23rd, 24th, 26th, 27th, 28th, 29th, 30th, and 31st.

THE SECTIONS.

BRIEF SUMMARY OF PROCEEDINGS.

SECTION OF ANATOMY AND PHYSIOLOGY.

Thursday, July 29th, 1909.

THE proceedings began with a paper on the development of the epithelial elements of the ovary by Dr. H. Louise McIlroy, the meeting being held jointly with the Section of Obstetrics. Miss McIlroy, from observations on the puppy, kitten, pig, and the human species in the early fetal condition, had concluded that the embryonic germ cells growing from the surface of the ovary into the deeper parts formed two distinct cellular structures, and that Pflüger's tubules, which had been a considerable source of worry to workers in this field, were nothing more than tubules of follicle cells from which the oocyte had fallen out. Dr. Waterston pointed out that practically all the stages of ovum formation could be found in sections of the adult ovary. Oogenesis was not confined to embryonic life, but was continued during a long period. He had made a number of observations upon the later stages of oogenesis in a number of different mammals, and traced the history of the follicle cells onwards to the final stages, and showed their nutritive character and the part which they played in the formation of the zona pellucida. In opening the discussion on the deep afferents, their function and distribution, Professor C. S. Sherrington, in an admirably lucid address, said it would be necessary to limit his observations to two main groups of afferents—(1) visceral and (2) somatic or muscular. He referred at the outset to the fact that when food is swallowed there is a point in the fauces beyond which, under normal conditions, no field of consciousness exists. The mouth is the intermediary zone between the external areas of sensation and the "blank inside." Therefore, in this portal of entry to the alimentary canal certain striking features were found, namely, that chemical agents were able to stimulate the appropriate nerves and produce sensations. Beyond this point sensations did not arise. Co-ordinating factors did exist, however, between the various parts of the alimentary canal, their action being exerted, according to modern researches, through the medium of the blood, any nervous adjustment being doubtful. From this point Professor Sherrington passed to the consideration of pain in viscera, and explained how the views of Lennander and Meltzer were diametrically opposed. He himself was inclined to believe that there must be some sensation, since reactions could be obtained by acting on the sympathetic system going to viscera. There resulted vasomotor reactions—a rise of blood pressure—and it was difficult to believe that there was no sensation associated with this phenomenon. But the animals being anaesthetized, it was impossible to be certain about this. The views of Head and Mackenzie were then considered, and again there was a wide divergence of opinion on visceral pain. Professor Sherrington next passed to the consideration of deep afferents which are not visceral, but are deep, that is, "deep touches." These deep touches were registered by muscular nerves. Nerve fibres going to muscle were heavily laden with afferent fibres—more than half. Where the muscles passed into the tendon, was a regular nest of afferent fibres, and in tendons, Golgi's organ was present—which again was an afferent structure. Tonus occurred in extensor muscles; it might occur in the flexors, too, but there was no proof of this. Briefly, tonus was present in those muscles which antagonized gravity. In conclusion, Professor Sherrington observed that the whole system of afferents formed an important group, for a study of which clinicians, physiologists, and anatomists might combine and attack certain problems, such as (1) the distribution of afferent nerves in muscles of different type and shape; and (2) the distribution of visceral afferents, concerning which there were so many discrepancies. In the subsequent discussion Professor Milroy, Professor Dixon, Professor Macdonald, Dr. Haddon, Dr. Graham-Brown, Dr. R. J. Anderson, and Dr. Rutherford took part. Professor Sherrington briefly replied. Dr. Waterston demonstrated some reconstruction models of the fetal pelvis, which had been built under his supervision by Dr. Pattie. He also showed Lissauer's instrument for taking outline tracings of the skull in various planes; also Martin's instrument and an improved form of Matthews's periglyph. A paper was read by Dr. Milroy from Dr. Leonard Hill, which was of the nature of a reply to Haldane and Douglas, who, in the *Proceedings of the Physiological Society*, June 26th, 1909, have stated that "Hill's recent observations as to the effects of previous inhalation of oxygen in diminishing distress caused by muscular exertion can be explained as a result of the deep breathing which is apt to occur in persons to whom oxygen is administered."

Friday, July 30th, 1909.

Dr. J. S. Goodall and Mr. H. G. Earle (Middlesex Hospital, London) read a paper, illustrated by lantern slides, on the structure of the pancreas in relation to function. The three essential points which they brought forward were (1) that the structure of the elasmobranch pancreas is the same as that of other vertebrates; (2) that in the elasmobranch pancreas structures are found which only exist in other vertebrates in an embryonic condition; (3) that there is continuity between the zymogenous tissue, islet tissue, and the duct. Professor B. Moore (Liverpool), in a communication on the biochemistry of haemolysis, pointed out that the red blood corpuscles contained lecithin, which was of the nature of a membrane or cement, and that all haemolytics had the property of dissolving lecithin membrane and the fats of fatty acids. Haemolytics might be classified in three groups: (1) Fatty acids and their soaps; (2) bile salts and their derivatives; (3) glucosides of the saponin-digitalin group. On introduction into the circulation they caused slowing of the heart, and stoppage in a condition of systole. Another property which these bodies possessed was that of causing conjugation with other substances to form more complex molecules. The latter part of the communication dealt with the "balancing" action of haemolytic bodies, an action which, in certain cases of combination, resulted in failure to act on the red blood corpuscles, whilst in other combinations union took place, the "balancing" action was lost, and both attacked the corpuscles. Dr. H. M. Johnston read a paper on the distribution of the intercostal nerves, from which it was apparent that these nerves give off many branches to the pleura and subpleural tissue, whilst others arising from the white rami communicantes of the lower thoracic nerves proceed to supply the diaphragm. Professor Peter Thompson gave a demonstration of the development of the human heart in the first month. He showed three models of reconstructed hearts from human embryos of 2.5 mm., 3 mm., and 7 mm. A special feature which they illustrated was the changes in position of the U-shaped ventricular loop in the third and fourth weeks of intrauterine life. Other points dealt with were the fate of the sinus venosus, the formation of the right and left venous valves, and the appearance of the aortic end of the heart tube. Dr. Dickey gave a lantern demonstration on the cervical pleura. He had dissected it in thirteen adults with a view to determining its surface relationships to the clavicles and sterno-mastoids, etc. He had taken measurements of the

thoracic inlet and the mean breadth of the sterno-mastoids from a topographical point of view. In his research he had utilized eight male and five female subjects. Mr. Norman Rutherford (Edinburgh) demonstrated an excellent model, reconstructed from wax plates, of the chondro-cranium of the trout at the time of hatching. The model included also the brain, cranial nerves, and sense organs, the whole forming a complete picture of the anatomy of the head region. It was probably unique in combining so many structures in the one model. As far as the chondro-cranium was concerned, it took an almost exactly intermediate position between the models made by Stöhr in 1882 of the earliest stages and that made by Gaupp of the Stadium Optimum of the teleostean primordial cranium. The last two papers were communicated by Professor R. J. Anderson (Galway), and proved to be most interesting both to the anatomist and physiologist. The first dealt with some results of the uniformity of action and habit; and the second with characters that make for persistence, particularly as regards the skeleton. Many suggestive points were raised, but the lateness of the hour prevented any adequate discussion.

SECTION OF DERMATOLOGY AND ELECTRO-THERAPEUTICS.

Thursday, July 30th, 1909.

AFTER the exhibition of some cases of skin affections —including one case of acanthosis nigricans—by various members, Sir Malcolm Morris (London) opened a discussion on mucous membrane lesions. He dealt separately with a great number of these, as seen in practice associated with the principal kinds of skin affections. In urticaria the mucous membranes of eyelids, lips, mouth, tongue, pharynx, and vulva might be the seat of wheals. In lichen planus the mucous membrane of the mouth was not infrequently attacked, and the condition was sometimes diagnosed as leukoplakia. Among the manifestations of tuberculosis on the mucous membrane, the most important was lupus vulgaris. In a large proportion of cases the starting point of the disease was certainly in the nose, from which it spread to the face. In leprosy, he said, the disease probably showed itself first on the mucous membrane of the throat and upper air passages; it might also begin in inflammation of the mucous lining of the nose. The speaker urged the importance in all cases of skin disease of examining the mucous membrane of the mouth and nose; but since lesions situated there were seldom sufficiently characteristic to form the basis of a diagnosis, the recognition of their true nature, in the absence of any dermal affection which might throw light upon the case, presented enormous difficulty. When the mucous membranes alone were the seat of lesions, syphilis was always the first thing to be thought of, but it was most important to remember that there were conditions not commonly met with—notably, herpes of the prepuce or vagina, lupus, and true leukoplakia—which were wholly independent of syphilis. Dr. Louis Wickham (Paris) and Dr. R. B. Wild (Manchester) also laid emphasis on the need for making thorough examination of the mucous membranes in all cases of skin disease. The latter said that lupus vulgaris, which by all outward appearance, was limited to a few spots, was sometimes found on deeper examination to have involved unnoticed a large portion of the mucous membrane of the nose. Dr. Sequeira (London) had also been impressed by the importance of early diagnosis of lupus of the nose. He thought that a large number of such cases had been overlooked, even by the specialist. Dr. Goodwin Tomkinson (Glasgow), in a paper on the etiology and treatment of pruritus ani, spoke highly of the benefits to be derived from spa treatment in this distressing condition. He had observed marked amelioration follow a course of Harrogate strong sulphur water. Among the various things suggested for local application, he inclined to the use of tar preparations, and also counselled for temporary relief the use of water as hot as could be borne. Dr. Humphris (London) advocated static electricity for this condition, and Dr. Metcalfe (Bradford) pointed out that a frequently unrecognized cause of pruritus ani was the *Oxyuris vermicularis*, and that many persons suffered from the irritation of this parasite during the whole of their lives. Two cases of acanthosis nigricans were described in separate papers, the one by Dr. R. B. Wild (Manchester) and the other by Dr. St. George (Lisburn). Dr. Wild noted the occurrence of this disease among persons who were subjected to great heat in the course of their work; his own case was that of a sugar-boiler. Dr. St. George said that no drug or combination of drugs could be depended on for a cure in this condition, and all that could be done was to make the patient observe hygienic principles and have plenty of open air.

Friday, July 30th, 1909.

The greater part of the sitting was devoted to a discussion of the supposed risks attending the *x*-ray treatment of ringworm. The subject was opened by Mr. R. Higham Cooper (University College, London). Speaking of brain injury, he noted the total absence of authoritative records of its occurrence among the many thousands of cases which had been treated. He was of opinion that with the most ordinary care such injuries were not possible; but, granting the possibility of their occurrence, he would limit them to cases in which a hard tube was employed, and would consider all risk absolutely avoided when the patient was treated with a moderately soft one. Dr. Margaret Dobson (Bradford) said that during the past four or five months she had treated 270 ringworm patches by means of the *x* rays, and in the 3 cases out of that number in which the disease was due to the *Megalosporon endothrix* the patches, in one case after twenty-four hours and in a second after ten days, swelled up, the skin becoming raised, oedematous, and glossy, and the hairs loose. In such cases, she thought, there was a greater risk of burning the scalp and producing permanent baldness. Professor Wild (Manchester) thought that it was easy to exaggerate the importance of scalp ringworm, which in itself was rarely serious, and he condemned the proposed compulsory treatment by the *x* rays. Dr. Sequeira (London Hospital) said that the risk of injury to the brain was purely imaginary, but he suggested that no child under 3 years of age should have its scalp irradiated. He had followed up 267 of his patients who had been inmates of orphan asylums and the like, and who, after treatment, had been under the expert observation of the medical officers and teachers, and not a single case of mental abnormality following *x*-ray treatment had been observed. He was of opinion that with proper apparatus used with sufficient care, and according to Sabouraud's instructions, the *x*-ray treatment was efficient, rapid, and safe. But, as a precautionary measure, he personally insisted on the parents and guardians understanding the nature of the treatment, and giving a written guarantee that no liability was incurred. Dr. Goodwin Tomkinson (Glasgow) also believed that the possibility of cerebral injury was entirely chimerical, as was proved by the vast number of cases successfully treated, not only in this country but also in Paris. Dr. R. W. MacKenna (Liverpool) suggested raising the age-limit under which the scalp of no child should be subjected to irradiation to 5 years. Dr. Howard Pirie (London) related an instance in which an overdose was given, resulting in permanent baldness over a patch of the scalp and temporary weakness of health and skin eruption. The child made an excellent recovery, however, and no brain symptoms were noted. Dr. Ernest Dore (London) referred to the fact that the smaller doses of *x* rays had a temporary stimulating effect, and suggested that if overdoses were making "idiots wholesale," it was reasonable to assume that they were also making statesmen, poets, artists, and the like by stimulating doses! Dr. Metcalfe (Bradford), Dr. Howell (Middlesbrough), and Dr. Humphris (London) also took part in the discussion, and at the close, in another paper, Dr. Hall-Edwards (Birmingham) dealt with the cognate subject of special

susceptibility to *x* rays, and said that, apart from the allaying of pain, he had failed to note any effect upon the nervous system, except in very advanced cases of chronic *x*-ray dermatitis such as his own. In the course of short papers, Dr. Howard Humphris dealt with the subject of static electricity; Dr. Hazleton, with the *x* rays in gynaecology; and Dr. S. W. Allworthy, with a case of cutaneous actinomycosis.

SECTION OF DISEASES OF CHILDREN.

Thursday, July 29th, 1909.

THE most important item in the day's programme in this Section was a discussion on functional neuroses in children, opened by Dr. J. A. Coutts, of London. After dealing with faulty deglutition and congenital dyspnoea, he passed on to pyloric stenosis, of which he had some doubt as to whether it could fairly be classed as a purely functional neurosis, seeing there was some difference of opinion as to whether it really originated solely in gastric spasm. Dr. Robert Hutchison's views as to its frequency and its invariable curability by medical treatment alone, were, he thought, contrary to the experience of some other observers. The speaker also pointed out the relation between cyclic vomiting and migraine, and dealt briefly with incontinence of urine and faeces, with night-terrors, nightmare, tic, chorea, hysteria, and habit-spasm. Dr. G. E. Shuttleworth (London) drew attention to the close interdependence of neurotic conditions in children on one another, and criticized the romantic character of the picture-books now in vogue for children. He showed also how readily morbid fancies passed into permanent obsessions. Mr. Sydney Stephenson (London) remarked on the necessity for correcting errors of refraction, the relief of which often had a magical effect in removing blinking and similar functional neuroses in children. Dr. George Carpenter (London) enlarged on the difficulty of separating purely functional cases from those which ultimately proved to have an organic lesion underlying them. Dr. Essex Wynter (London) insisted on the much more rapid cure of acute cases of chorea with chloretone, the average duration being reduced to nine days. At the same time the drug might produce peeling of the hands and feet or erythematous rashes. Dr. J. W. Simpson (Edinburgh) stated clearly the divergence of opinion prevailing with regard to pyloric stenosis, its frequency, its pathology, and treatment, whether operative or medical. Dr. R. W. Leslie (Belfast) confirmed the value of chloretone in chorea, and described *Rhus aromatica* as a useful remedy for enuresis. Dr. McCaw (Belfast) described a fatal case of pyloric hypertrophy where the redundant gastric mucous membrane formed a valve impermeable to fluids. The President (Mr. H. J. Stiles of Edinburgh) was convinced that genuine cases of pyloric stenosis were amenable to nothing short of surgical measures. The condition might sometimes be traced to intestinal disturbance, apart from gastric troubles. Dr. Coutts, replying, thought chloretone should be used with caution, especially in private practice. He had limited the carbohydrates in enuresis without any apparent benefit. Mr. Alexander MacLennan (Glasgow), read a paper on Madelung's subluxation of the wrists, illustrated by photographs and skiagrams of cases before and after cuneiform osteotomy. He also exhibited a series of stereoscopic pictures of various interesting conditions in infancy and childhood. Dr. A. Dingwall Fordyce (Edinburgh) contributed an analysis of 137 cases of abdominal tuberculosis in young children, where the abdominal condition was uncomplicated by lesions elsewhere. The rôle of diet was considered, and the vagaries of the temperature in these cases discussed.

Friday, July 30th, 1909.

The last day's programme in this Section included a paper by Mr. E. Scott Carmichael (Edinburgh) on pneumococcal peritonitis in children. Twenty cases of this nature observed by the author had been divided by him into three classes, according as the main channel of infection was genital, haemic, or gastro-intestinal. On laparotomy the absence of odour about the peritoneal fluid and its other characteristics, according to the stage of the disease, afforded valuable diagnostic evidence. In spite of the bad prognosis 13 out of the 20 cases recovered. Free drainage of the abdomen was the first essential. The paper was discussed by Mr. D'Arcy Power, Dr. J. McCaw, and Dr. John Campbell. Mr. G. H. Edington (Glasgow) narrated a case of prostatic sarcoma in a boy of 21 months at first presenting only comparatively trivial urinary symptoms. On *post-mortem* examination a spindle-celled sarcoma undergoing myxomatous degeneration was found, the same change being noted in the pelvic lymph glands, while the kidneys were cirrhotic. Mr. D'Arcy Power pointed out the frequency of similar polypoid sarcoma in girls, in whom they originated near the neck of the bladder. Mr. Carmichael, Dr. J. Campbell, and Mr. Stiles described similar cases, and Mr. A. Fullerton urged the value of cystoscopic examination by perineal urethrotomy. Mr. J. H. Nicoll (Glasgow) read a paper on the surgery of infancy, being a review of twenty years' work at a children's hospital. He felt that the resources of the hospital as regards operations on infants might be greatly extended by making the children out-patients rather than in-patients. Mr Stiles, Dr. J. Campbell, Dr. J. W. Simpson, Mr. A. Fullerton, Mr. E. S. Carmichael, Mr. R. C. Dun, Mr. A. MacLennan, and Mr. G. H. Edington criticized and supported Mr. Nicoll's main conclusions. Mr. D'Arcy Power contributed a paper on the value of new tuberculin (T.R.) in surgical tuberculosis, which was discussed by several speakers. Mr. R. C. Dun (Liverpool) read a communication on the association of a patent funicular process with certain forms of hydrocele, and described two cases of median hare-lip, while Mr. Maynard Smith (London) read a paper on exomphalos. This brought the proceedings to a close.

SECTION OF HAEMATOLOGY AND VACCINE THERAPY.

Friday, July 30th, 1909.

WORK began with the reading of a paper on the micro-organism of whooping-cough by Dr. Bordet of the Institut Pasteur du Brabant, Brussels. Working with Dr. Gengou in 1906, a small cocco-bacillus, non-motile, Gram-negative, and staining feebly, was isolated, which they regarded as the cause of whooping-cough. The organism was found in large numbers, often in almost pure culture, in the exudate at the beginning of the period of cough. The pure cultures were difficult to obtain, and required a special medium. The best medium for their isolation was agar mixed with defibrinated blood, and even with this isolation was difficult if the exudate contained many contaminating organisms. The organism resembled in certain respects the cocco-bacillus of influenza (Pfeiffer), but it was readily distinguished from it by the appearance of the culture and by the reaction of immune serums. The filtrate of liquid cultures did not appear to possess any very evident toxic properties, but by Besredka's method for obtaining endotoxins a very active toxin could be obtained. The serum of children lately recovered from whooping-cough conferred upon the organism the power of absorbing complement with great vigour, and this was an additional proof that the organism was specific. Dr. Fleming replied and discussed the extreme difficulty of isolating the organism described by Bordet, and described its characters more fully. He became convinced of the specificity of Bordet's bacillus when he found that cultures obtained from M. Bordet in Brussels were specifically agglutinated by the serum of children in London, and would also deflect complement with such serums. He pointed out that the agglutinating reaction of the serum was not strong; complete agglutination in sixty-fold dilution was about the highest found. The agglutination did not always take place, failure often seeming to depend on the bacterial emulsion employed. He considered a convincing proof of the specificity of the organism was

found in the results obtained by vaccine-therapy, and judging from the clinical results he had obtained by the use of a vaccine he thought the evidence was in favour of the use of a vaccine in whooping-cough. Drs. Willcox and Morgan read a paper on the treatment of pneumonia by inoculation, giving the results obtained in the treatment of 24 cases of pneumonia, either lobar or lobular. In all cases the organism present was the pneumococcus; in two cases this was combined with a streptococcus and the influenza bacillus respectively. The inoculations were not controlled by the opsonic index on account of difficulties in its use which the author described, and clinical symptoms were therefore taken as a guide to the dose. The authors claimed to have obtained distinctly good results by the inoculation of from 20 million to 50 million of pneumococci. Dr. Benham read a paper on the bacteriology and vaccine-therapy of the common cold. He described several organisms which he considered of importance in the etiology of a common cold and held out a hope that vaccine-therapy might eventually be a successful method of treating this unpleasant and sometimes dangerous condition. Dr. W. Carmalt-Jones read a paper on the treatment of bronchial asthma by a vaccine; he suggested that one cause of spasmodic dyspnoea was a specific bacterial toxin, the result of a definite infection and amenable to treatment by the corresponding vaccine. Dr. Fleming discussed the bacteriology and vaccine-therapy of acne vulgaris, and pointed out the importance of distinguishing acne vulgaris very carefully from other diseases to which the name of acne has been applied, and especially from acne rosacea.

SECTION OF HYGIENE AND PUBLIC HEALTH.

Thursday, July 29th, 1909.

THE meeting of the Section of Hygiene and Public Health was held in conjunction with the Laryngological Section, the subject for discussion being latent infections by the diphtheria bacillus and the administrative measures required for dealing with contacts. The discussion was opened by Dr. Watson Williams of Bristol, who treated it from the clinical standpoint. His remarks are reported under the proceedings of the Laryngological Section. Dr. R. M. Buchanan of Glasgow dealt with the subject from the bacteriological standpoint. He stated that the clinical significance of the distribution of diphtheria bacilli was very indefinite, and rendered the diagnosis of the disease apart from bacteriological methods difficult and uncertain. The difficulty of classification of different types of the bacillus was very great, owing to the personal equation of different observers. The diphtheria bacillus was most tenacious of its virulence. The speaker considered that systematic examination of contacts was a recognized preventive measure in public health administration. During the last three years there had been 2,305 such examinations in Glasgow, with a positive result in 211, or a little over 9 per cent. The experience of the fever hospitals in Glasgow showed that spread of infection by return cases was very limited, the average having been 8.5 per annum in three and a half years. In his opinion, infection by contacts occurred much seldomer than might have been anticipated. This paper was illustrated by several lantern slides of different types of diphtheria bacilli and by statistical charts. Dr. Forbes (M.O.H., Brighton), in a paper on the administrative measures required for dealing with diphtheria contacts, said that in future legislation dealing with infectious disease it would be advisable to substitute the words "persons in an infective condition" for "persons suffering from an infectious disease." This would give the necessary discretionary power to the medical officer of health and clear away the present ambiguity. He pointed out the importance of taking swabs from both the throat and nose in dealing with contacts, and outlined the administrative measures which he recommended in order to check the spread of disease by contacts. He considered that prophylactic injections of antitoxin for contacts were as a rule inadvisable. Dr. R. V. Clark (Assistant M.O.H., Leeds) dealt with latent diphtheria in schools and institutions. He considered that the incidence of cases of latent diphtheria was greatest when personal contact was closest. In his opinion the only thoroughly efficient procedure was to examine bacteriologically the throats of every member of a family when diphtheria occurred, and to isolate those from whom a positive result was obtained. This isolation should be carried out for from one to seven weeks. After a few remarks by Dr. Renshaw and Dr. McKenzie, Dr. E. W. Goodall (London) remarked that return cases of diphtheria were not worth talking about. In the treatment of convalescents he did not think it mattered a bit whether swabs were taken or not. He only did it himself in order to comply with the requests of the medical officer of health. He considered it unnecessary to empty and disinfect wards in general hospitals when an accidental case of diphtheria occurred. He considered prophylactic injections of antitoxin quite unnecessary and sometimes dangerous. Dr. Herbert Jones (Hereford) said that his experience in Herefordshire led him to agree with Drs. Davies and Heaven, of Bristol, that in the presence of an outbreak of diphtheria Hoffmann's bacilli must not be ignored. Drs. StClair Thomson, Clements, Spicer, Williams, Wyllie, and Mowbray also spoke. The President, in closing the discussion, said that he agreed with Dr. Goodall's views as to administrative methods, and that it was not justifiable to send contacts to diphtheria wards. The diphtheria bacillus was much more virulent in times of epidemic prevalence of the disease than under ordinary conditions, and while special measures might be required to cope with an epidemic, in ordinary circumstances he did not consider that either isolation of contacts or systematic swabbing of throats was necessary. Dr. Watson Williams, Dr. Buchanan, and Dr. Forbes, having briefly replied, the meeting adjourned.

Friday, July 30th, 1909.

The Section was mainly occupied with a discussion on the discharge of sewage effluents into tidal waters. This was opened by Dr. Henry O'Neill, member of the City Council, Belfast, who pointed out that the problem of sewage purification in Belfast was one of more than ordinary difficulty, owing to the sluggish tides and large areas of shallow water in the upper reaches of Belfast Lough; they favoured the growth of *Ulva latissima*, a green seaweed which, according to the investigations of Professor Letts, is an indication of sewage pollution. Dr. O'Neill gave a most interesting account of the Belfast sewage purification works, illustrated by photographs of the various processes. The great difficulty was getting rid of the *Ulva latissima*, which object must be attained by depriving it of its pabulum. By mixing the effluent from percolating filters with an equal quantity of septic sewage and treating the mixture in contact beds, the organic matter was oxidized at the expense of the nitrates in the filter effluent, and the total quantity of ulva pabulum reduced. Two methods of disposal of the sludge were proposed: (1) At the main outfall works it would be conveyed to sea by steamer; (2) at the Sydenham outfall, as shallow water rendered steamer disposal expensive and inconvenient, Dibdin's slate beds, which converted the sludge into an inoffensive humus, would be installed. An effort to deal with the ulva nuisance had been made by the formation of a joint board of the Belfast, Holywood, and Castlereagh authorities, who had been expending £2,000 a year on the collection of the weed from the foreshore, some 20,000 tons having been removed last year. Professor Letts of Belfast read a paper dealing with the nuisance caused by certain green seaweeds due to the discharge of sewage into tidal waters. He related his experiments dealing with the chemistry of these seaweeds, and outlined in detail the scheme of sewage treatment which he had suggested in order to prevent the green seaweed nuisance. Dr. R. J. Ewart, Assistant Medical Officer of Health for Middlesbrough, dealt with the sewage pollution of the Tees estuary,

especially with regard to pollution of mussels. He came to the conclusion that it was possible to obtain mussels free from all evidence of sewage pollution, and that there was a close relationship between size, number, and sewage pollution, for it appeared that when the mussels were of sufficient size to be marketable and in sufficient quantities to be worth gathering, evidence of pollution was marked. He considered that mussels could not be looked on as safe, especially as they were apt to die in transit to inland towns, when the bacterial contents would rise by millions. Professor Dunbar, of Hamburg, expressed his high appreciation of Professor Letts's work. He pointed out that it was only lately that the difficulty of dealing with sewage effluents in tidal waters had been thoroughly realized. After the cholera epidemic in Hamburg in 1892 experiments had been made with various disinfectants with a view to sterilizing the sewage. Milk of lime was found too costly, and the most satisfactory disinfectant was found to be hypochlorite of lime, but as its penetrating power was only $\frac{1}{2}$ mm. for crude sewage, it was necessary first to purify the sewage by means of septic tanks before trying to disinfect it. In Hamburg the question of shellfish pollution was not important, and their experience had led them to discard the purification of sewage, except that from hospitals, from emigrant stations where so many Russian emigrants congregated, and the waste water from the Hygienic Institute. Dr. Wilson demonstrated an apparatus for the isolation of the *Bacillus typhosus* from drinking water. Sir Peter O'Connell alluded to the peculiar difficulties of the sewage problem as it affected Belfast. The President assured Professor Dunbar that the difficulties of disinfecting crude sewage were fully realized in this country. He was glad to hear the Professor saying that Germany had learnt lessons from England about sewage purification, as he thought it was often the other way about. After some remarks from Dr. Carnwath (Manchester) on the relation of mussels to sewage, the President proposed a vote of thanks to the writers of papers. This was seconded by Dr. Cowan, Chief Engineer, Local Government Board, Ireland, and passed unanimously. Dr. Patterson (Assistant M.O.H., St. Helens), read a paper on measles in schools, which was discussed by Drs. Mackenzie, Brook-Fox, H. Jones, and A. Walker. Dr. Gilchrist, of Nice, read a paper on the endemicity of influenza. He considered that we must recognize a chronic and permanent form of this disease. Dr. J. B. Story (Dublin) read a paper on the neglect of physical education in primary and secondary schools. The proceedings of the Section then closed with the usual votes of thanks.

SECTION OF LARYNGOLOGY, OTOLOGY, AND RHINOLOGY.

Thursday, July 29th, 1909.

THE Section combined with that of Hygiene to discuss latent infections by the diphtheria bacillus. It was introduced by Dr. Watson Williams (Bristol), who laid stress on the difficulty of recognizing such cases by clinical signs. It was necessary, he considered, to depend on the aid of the bacteriologist. He then instanced clinical phases of later infection, leaving the bacteriological diagnosis to the next speaker. The phases he grouped under three headings: First, those with no definite clinical symptom, but who are not well, and who present the bacillus; secondly, those with local lesions, but not ill; thirdly, those presenting bacillus and yet are quite well and have no local lesions. He gave many instances of these groups, and concluded by advocating a virulence test rather than a morphological one. He was followed by Dr. R. Buchanan (Glasgow), who read a paper illustrated by lantern slides, dealing with the subject from a purely bacteriological point of view. He laid stress on the difficulty of demarcation between latent infection and latent disease, the former being the presence of an infective agent bacteriologically unaccompanied by any obvious pathological change. He showed that the clinical evidences were indefinite, as of the swabs sent in for bacteriological examination only 31 per cent. showed positive results, and of those taken from cases admitted to hospital from 71 to 76 per cent. He recognized that morphology alone was not sufficient for true recognition of bacillus, and that inoculation was necessary. He considered that the virulence of bacilli from apparently healthy subjects was only slightly less than that from infected cases. Dr. Duncan Forbes (Brighton), read a paper dealing with the same subject from an administrative standpoint and its relationship to the medical practitioner. The latter he urged always to take a swab from the nose after its examination, and make a note as to the clinical appearances. He was followed by Dr. Clarke (Assistant M.O.H., Leeds) upon somewhat similar lines. There was an interesting discussion in which widely divergent views were expressed as to the importance of bacteriological examination of swabs from the throat and nose, and isolation of infected patients and of contacts. Views ranged from uniform swabbing of contact carriers, with isolation in certain cases, together with the virulence test, to allowing Nature to exterminate the susceptible by epidemics, which then practically died out. This last view, however, did not meet with general acceptance, which lay rather on the side of bacteriological diagnosis and virulence tests. This was the line taken by Drs. Knowles Renshaw and Dan McKenzie, while Drs. Goodall and Herbert Jones rather doubted its value, the former thinking prophylaxis of little importance. Dr. StClair Thomson referred to the practical difficulties from the laryngologist's point of view. The value or otherwise of the presence of the Hoffmann type of bacillus was discussed by succeeding speakers, among whom were Drs. Clements, Scanes-Spicer, Wyllie, Mowbray, and the President of the Public Health Section (Dr. Louis Parkes). Drs. Watson Williams, Buchanan, and Clarke briefly replied.

Friday, July 30th, 1909.

Dr. Lack, in a paper on the treatment of cicatricial stenosis of the larynx and trachea following diphtheritic tracheotomy cases, held that the disease had no direct connexion with the subsequent stenosis, which was due to the tracheotomy. In cases of a genuine low tracheotomy he had never known any laryngeal stenosis follow. Where there had been no sloughing or necrosis of the cartilages he thought that his objection to interference with the larynx itself extended to intubation. Dr. Delavan of New York, in an interesting paper, spoke of O'Dwyer in eulogistic terms, and referred to the methods of treatment prior to his time. There were three essential objects in a case: (1) Relief of the stricture; (2) permanence of result; (3) as little injury to the parts as possible. He gave a summary of various cases, and referred to certain anatomical conditions upon which the principles of intubation were based, and believed that prolonged stretching of scar tissue finally resulted in its giving. For this purpose each case should have its own tube made to suit the special conditions present, and no tension should be made for at least one month. The paper was illustrated by the passing round of the various kinds of instruments used. A spasm of the adductors after removal of the tube was mentioned, and its diagnosis, whether due to nervous elements or otherwise, was pointed out. He finally referred to the latest form of laryngo-fissure, but considered that it was too early as yet to be definite upon its results. Dr. Delsaux then described the operation of laryngo-tracheostomy, and the conditions in which it was indicated. Some of the tubes employed were passed round for inspection. The operation was divided into its various stages, and he spoke of the length of continuance of treatment which might extend beyond twelve months. The methods of removal of the tube and the teaching of the patient to breathe in a normal way was then indicated. Dr. Emil Mayer gave a history of 3 cases, a traumatic, an inflammatory, and a neoplastic stenosis treated by intubation, and passed round for inspection his special hollow instrument for a slow insertion of the tube, which enabled the patient to breathe through it during its introduction. Dr. Hill made remarks upon a special

case, for which he had devised an intralaryngeal splint, of the prevention of cicatrical formation in the larynx after the division of transverse webs and the like. Drs. Logan Turner, Barnett, and Scanes-Spicer joined in the discussion which followed, and the President summed up in a few remarks. Drs. Delavan and Delsaux replied. Dr. Scanes-Spicer, in a paper on the relationships of cancer of the larynx, laid stress upon the effect of various physical forces upon the body generally and their reaction upon the vocal organs, illustrating it by means of a model. He considered that the position of and pressure upon the larynx during abdominal and thoracic respiration was a possible factor in cancer growth. Dr. Woods showed a patient whose larynx he had extirpated, and explained a vocalizing apparatus he had devised. The proceedings terminated with the reading of a paper on the surgical anatomy of the tonsils in the absence of the author, Dr. Neil (New Zealand), by Dr. J. S. Barr.

SECTION OF MEDICINE.

Thursday, July 29th, 1909.

A DISCUSSION on the medical aspects of athleticism was opened by Dr. Tyrrell Brooks (Oxford) and Dr. Clement Dukes (Rugby). Dr. Brooks said his experience was that the more vigorous undergraduates came from schools whose athletics were of the more strenuous type. An inquiry to the medical officers of the principal public schools as to the influence of athletics on health extending over a period of twenty years gave five deaths, almost exclusively from surgical injuries during games, but among the same boys during the same time four sudden deaths occurred quite apart from athletics. At Oxford during the same time there were two deaths from excess in athletics, but one was in the subject of aortic valvular disease. As to the heart, valvular damage was very rare, and slight dilatation of the heart was difficult to estimate. Excessive smoking, alcoholic indulgence, gluttony, or sexual excess might produce perversion effects on the heart's action exactly similar to those of over-exertion, and the toxins of acute febrile attacks had a similar action. But in boyhood it was unlikely that mere muscular exercise could seriously damage the heart. Among precautions that should be taken to minimize the risks arising from athletics were an entrance physical examination, careful observation of younger boys in their ordinary games, and an ample interval between the previous meal and active exercise, with special care after convalescence from acute illness. With such precautions he supported the system of school runs. The profession should not, he thought, sacrifice the interests of the race to the interests of the individual. Dr. Clement Dukes said that the catastrophes from over-exercise were quite preventable. In addition to the points already mentioned in his abstract published in the SUPPLEMENT of the BRITISH MEDICAL JOURNAL, he especially referred to the evil effects of excessive football and running. The short, quick runs in boys were apt to produce rapid mischief in the heart, which quickly disappeared, the long runs permanent damage by dilatation. At least an hour between a meal and active exertion was imperative. Details of the serious effects of excessive running at Rugby in former days were given, but owing to the practical rules now there in force these were a thing of the past. Sir Clifford Allbutt referred to the blood-pressure observations on the effects of athletics at Cambridge, the results of which were to be shortly published. The only serious results were those from over-exertion after an acute infectious disease, particularly a bad cold. Sir Lauder Brunton said the ideal training of youths was probably a combination of gymnastic exercises and games. He advocated the establishment in the schools of this country of the office of games master. The Provost of Trinity College, Dublin (Dr. Anthony Traill), referred to the introduction of Swedish drill into the schools of Ireland, and insisted on previous medical examination and the necessity for suitable feeding of the children. He discussed the effects of physical exercise on moral states, and gave personal experience of lifelong following of athletics. Sir James Barr referred to the influence of exercise on character, to the strain of the heart by its self-generated stress, and the importance of respiratory capacity. Dr. Clive Riviere described the effects of heart strain of arduous holiday excursions in boys. Dr. Gullan advocated games rather than gymnastics. Dr. W. J. Tyson urged a continuous individual interest in athletics, the teaching of health laws to school children, and the personal continuance of physical exercises throughout life. Dr. W. P. Kennedy referred to the question of pulmonary haemorrhage in athletes. Dr. Brooks and Dr. Dukes replied. Dr. P. Dempsey showed a case of argyria in the subject of a gastric ulcer, and Professor B. Moore an apparatus for administering known quantities of oxygen. Dr. Clive Riviere read a paper on cardiac strain in boys, and Dr. F. C. Eve one on a case of glycosuria which was only to be inferred from the presence of gas and bacilli in the urine.

Friday, July 30th, 1909.

On the third day of the meeting of this Section Dr. Theodore Thompson and Dr. H. S. Souttar gave a demonstration on gastric illumination. The mechanical features of the instrument they employed were demonstrated by Dr. Souttar, and its sphere of usefulness in observation and diagnosis was described by Dr. Thompson. Dr. Gordon Gullan read a paper describing an obscure case of hour-glass contraction of the stomach with special referencce to diagnosis. Dr. Purves Stewart described the technique and results of Schlösser's method of the treatment of tic-douloureux, the injection of alcohol into the foramen of exit of one or other branches of the fifth nerve at the floor of the skull. Freedom from pain was secured for many months after each injection. The operation was demonstrated on a patient before the Section. The paper was discussed by Dr. W. P. Kennedy, Mr. H. A. Ballance, Dr. J. H. Williams, Dr. F. Kennedy, and Dr. O'Sullivan. Dr. J. H. Williams (Washington) read a paper on the treatment of tabes dorsalis by antisyphilitic remedies, especially the intravenous or intramuscular injection of mercurial solutions. The paper was discussed by Dr. Theodore Thompson and Dr. Gullan. Dr. H. D. Rolleston read a paper on pruritus in lymphadenoma, maintaining that if pruritus occurred early in the disease the prognosis was unfavourable.

NAVY, ARMY, AND AMBULANCE SECTION.

Thursday, July 29th, 1909.

THE Section dealing with Navy, Army, and Ambulance work commenced proceedings on Thursday with the reading of a paper by Colonel P. Broome Giles, A.M.S., on the importance of the permanent attachment of ample transport under the command of the medical officer of each field medical unit. History and experience proved the failure of detailed transport for the use of medical units. The use of detailed transport, whether supplied on requisition from the Army Service Corps or hired from civilian sources, introduced serious complications. The wretched and inadequate results of using hired civilian transport, evident during drills and camp training, were intensified on manœuvres, and it was a most elusive idea to think that civilian wagons and harness would do for medical units. The advantages of the permanent attachment of ample transport under the command of the medical officer of each field medical unit were that the transport sections recruited for each medical unit would be homogeneous, and part and parcel of the permanent *personnel*. In Territorial Medical Units hired civilian transport could neither be popular nor successful. Fleet Surgeon P. W. Bassett-Smith, R.N., communicated a paper on modern methods of laboratory diagnosis of syphilis and discussed the Wassermann Neisser and Bruck's complemental fixation methods. The procedure employed by Fleet Surgeon Bassett-Smith was that recommended by Wassermann slightly modified,

using for antigen dried syphilitic congenital liver and the following were the conclusions which he reached: Almost all cases with evident primary syphilis gave a marked reaction, this being obtained as early as the fifteenth day after infection; in many cases admitted for chancroids the presence of a double infection was early indicated by the test; in almost all cases of early secondary syphilis, with or without symptoms at the time, positive results were obtained; in late secondary stages or tertiary manifestations the results were more variable; in about 50 per cent. of para-syphilitic cases a positive reaction was present; in cases without symptoms and generally after much treatment, but with an undoubted history, a minority reacted; the reaction was specific for syphilis as far as other venereal diseases were concerned; mercurial treatment did not appear to prevent the reaction when symptoms were present. The method was a valuable aid in the diagnosis of syphilis, and would decide the nature of many difficult cases, and indicate early the need of specific treatment. Colonel F. J. Lambkin, R.A.M.C., read a paper on the probable effects in the services of the new treatment of syphilis by means of organic arsenical compounds, and Major G. S. Crawford, R.A.M.C., contributed a paper on the beneficial results of recent sanitary work in Malta. A few years ago most service people looked upon Malta as a very undesirable station, and the chief reason for this opinion was the amount of sickness usually prevalent in the garrison; all that had been changed, and Malta was now known to be one of the healthiest of the foreign stations.

Friday, July 30th, 1909.

The concluding meeting of this Section commenced with the reading of a paper by Staff Surgeon F. F. Mahon, R.N., on relief work from a British man-of-war at Messina. Dr. J. M. Carvell then read a paper on the existing ambulance organization of the home railway companies, with suggestions for its amplification and unification. He said that the course of instruction which railway ambulance men went through was in accordance with the syllabus of the St. John Ambulance Association. It extended over a period of five weeks. There were five lectures with an interval of seven days between each, followed by an examination. The examination consisted of a practical and a theoretical portion. The theoretical was either by a written paper or by *viva voce* questions. In the majority of railway examinations the written paper was dispensed with, owing to the fact that the premises were not suitable. The examination consisted of at least five tests. In the practical part each candidate must treat a case of supposed fracture and a case of supposed haemorrhage, and then do either stretcher or hand seat exercise, or perform artificial respiration. In the *viva voce* two questions had to be answered. The maximum number of marks was 20 per test, making a total of 100. For a pass for a certificate a candidate must obtain 50 per cent. For a voucher for the first re-examination, twelve months having elapsed after obtaining a certificate, 55 per cent. of marks had to be obtained. For the medallion examination, taking place after a lapse of twelve months from obtaining the voucher, the pass standard was 60 per cent. For the label examinations, which would be entered for at intervals of twelve months, the first twelve months after obtaining the medallion, the standard was 60 per cent. Encouragement to take up ambulance work was given in different ways on different lines—such as rewards for proficiency, rewards for work done, additional passes, medals, certificates of honour, competitions, and prizes. The great incentive to railway ambulance work was the Inter-Railway Shield, which was offered for annual competition by the St. John Ambulance Association. Each railway had the right to send a team, consisting of five men, to compete. As to amplification, he considered that all railway ambulance men should be given an elementary knowledge of nursing and sanitation. The men's wives should also be encouraged to go through elementary instruction in home nursing and sick-room cookery. In regard to transport, all guards' vans should be fitted with rings in the roof for the suspension of stretchers, and looped ropes should be carried for attaching the stretchers to the rings. On those lines on which corridor trains were run, a percentage of stretchers should be provided with telescopic handles, as they could then be carried in the corridor compartments, when placed cornerwise. He thought the easiest method of unification would be through the St. John Ambulance Association. All railway companies, who had not already done so, should form centres of the Association. Then a Home Railway Committee should be formed, which could meet at St. John's Gate. The members of the Committee should be nominated by the railway companies and the St. John Ambulance Association. Captain W. Salisbury-Sharpe said that there appeared to be little co-operation or unity of method between the different railway companies respecting the way of keeping up the men's interest and efficiency in the work. Lieutenant-Colonel E. M. Wilson said he had listened with great interest to Dr. Carvell's paper, and agreed that it was more desirable to obtain a large number of efficient men than a few very highly trained squads for competition purposes. Mr. W. C. Rivers read a paper on rhinology as an aid to diagnosis of pulmonary tuberculosis, with special reference to the physically selected classes, and the work of the session came to an end with the reading of a paper on a detailed scheme for an unexpected landing party using material available on board ship by Staff Surgeon J. G. Wallis, R.N.

SECTION OF OBSTETRICS AND GYNAECOLOGY.

Thursday, July 29th, 1909.

THE Section commenced work at 9.30 a.m. by attending a demonstration on the development of the epithelial elements of the ovary. Notes respecting it will be found in the paragraph concerning the Section of Anatomy and Physiology, in whose room it took place. On return to its own quarters the President called upon Dr. Hastings Tweedy (Dublin) to open the discussion on endometritis. Dividing the cases into acute and chronic, Dr. Tweedy pointed out that in the former one must proceed upon general principles—collections of pus must be opened, necrotic matter removed, and before any douching a specimen of the discharge should be taken for the preparation of a vaccine. The patient's general system should be fortified, and any complication such as retroflexion rectified. He altogether condemned the use of the sharp curette. Chronic cases included all other non-malignant diseases of the uterus. Professor Fehling (Strassburg) thought that endometritis was less difficult to cure than endocervicitis. A sharp spoon was necessary for the cervix. Dr. A. Donald (Manchester) attached much importance to gauze packing in addition to dilatation and curettage, as it stimulated the uterus to contract and promoted involution. Professor Kidd (Dublin), like Professor Fehling, had found curettage to be followed by amenorrhoea. Dr. F. J. McCann (London) insisted on the necessity of supplementing curettage by a modified rest cure of from four to six weeks. Dr. Thomas Wilson (Birmingham) said that the indication for curettage was uterine haemorrhage. Professor Cullen (Baltimore) approved of the concise classification—(*a*) acute and chronic, (*b*) corporeal and cervical—adopted by Dr. Tweedy. A colleague of his own had described thirty-three different forms of endometritis, an affection which, except after abortion, he rarely saw in an acute form. He held that a sharp curette was absolutely necessary; a trial of the blunt curette on the uterus of the female cadaver ought to convince anybody. Professor Alfred Smith (Dublin) attached great importance to the so-called glandular hyperplastic endometritis, from its close resemblance to malignant disease. Professor Henry Corby (Cork) had known curettage to be followed by amenorrhoea for ten months and the birth of a healthy child. Dr. Buist (Dundee), Dr. T. B. Grimsdale (Liverpool), and Dr. E. J. Maclean (Cardiff) also joined in the discussion, and the President having emphatically declared in favour of the sharp spoon, Dr. Tweedy

replied. Dr. Smallwood Savage then read a paper entitled "An Ovarian Tumour, Clinically Malignant, arising from the Overgrowth of Lutein Cells," and showed the specimen with photomicrographs of sections of the growth. After some remarks from Professor Fehling, Dr. Munro Kerr, Dr. Edge, Dr. Louise McIlroy, and Dr. Hicks, from which it appeared that these growths were apt to be connected with vesicular mole, the meeting adjourned.

Friday, July 30th, 1909.

The last day's proceedings opened with a paper by Professor Fehling on the treatment of cases of contracted pelvis. He mentioned the method of limiting the diet proposed by Prochownik, saying that as fetal growth was most active towards the end of pregnancy good effects could be obtained by such restriction in the last six or eight weeks. The induction of premature labour he recommended, but only for primiparae. Walcher's position was useful, especially for the passage of the aftercoming head. With pubiotomy an increase of the true conjugate of from 0.5 to 2 c.cm. could be obtained in clinics, but in private practice the high forceps and perforation, even of the living child, could not be dispensed with. He was strongly in favour of pubiotomy and of Caesarean section on positive indications, but reserved as to the recently introduced extraperitoneal indications. As to relative indications for Caesarean section, each case must be judged on its own merit. Professor Murdoch Cameron (Glasgow) was strongly in favour of the induction of premature labour at from the thirty-fifth to the thirty-seventh week, as he thought the child had a better chance of survival than after Caesarean section. Dr. Munro Kerr insisted on the expediency of waiting, and pointed to the good results obtained at Queen Charlotte's Hospital. With the high forceps half the children were born dead. Dr. Hastings Tweedy considered that no contraction of the pelvis could be assumed without accurate measurements of the pelvis, for which the foreign and ordinary instruments were quite useless. He employed Skutsch's pelvimeter under an anaesthetic. The child's life should not be imperilled by too long delay; operation should be done before the fetal heart's action became slow. In reply, Professor Fehling said that Prochownik's limited feeding was essentially a method for the practitioner. Many Caesarean sections were performed upon primiparae and upon single women, and that accounted for the infantile mortality. In multiparae the induction of labour gave better results than Caesarean section; but, taking all cases in his clinic, this was not so. He preferred measuring the pelvis with his finger, under an anaesthetic if need be, and found it accurate enough. Professor Cameron read a paper on two cases of dystocia due to ventrifixation of the uterus. Professor Jacob spoke of three similar cases, and, after some remarks from Dr. McCann and Professor Murdoch Cameron, the meeting adjourned to the Ophthalmological Section for the joint discussion on the report of the Ophthalmia Neonatorum Committee, an account of which is given under the Section of Ophthalmology.

SECTION OF OPHTHALMOLOGY.

Thursday, July 29th, 1909.

PROFESSOR Fuchs (Vienna), in a paper on malformation of the cornea in cases of inherited syphilis, paid tribute to the work of Sir Jonathan Hutchinson on this subject. He himself had collected 28 cases last year, in which the cornea was oval, and of these 20 were girls and 14 had interstitial keratitis; it was a common condition in interstitial keratitis. The malformation was more frequently seen in both eyes; as a rule astigmatism was present "against the rule." Mr. Treacher Collins asked if Professor Fuchs had examined the cases anatomically or only clinically; some cases were apparent rather than real. Professor Fuchs said that in his cases the malformation was real. Dr. Inglis Pollock (Glasgow) read a paper on visual acuteness among school children. He gave statistics of the condition he found in which 77.8 per cent. had defective vision. Mr. Bishop Harman had found that myopia in school children was not more than about 2 to 3 per cent. Mr. Henry (Leicester) agreed with Mr. Harman, as the result of his experience in Leicester. Dr. Pollock replied. Dr. Freeland Fergus described a method of trephining for glaucoma which is a modification of Le Grange's operation. His trephines were very like those of Bowman's. He selected the position where the iris was the freest. He then dissected up the conjunctiva and cut out a circle from the sclera. In acute glaucoma he still preferred iridectomy, but for chronic cases he preferred the trephining operation. After the piece of sclera had been removed he then separated the ciliary body with a repositor. This operation could always be done under cocaine. Mr. Little thought that an eye in which a filtration scar was present was in a very dangerous state from the point of view of infection at any late period. Dr. Berry (Edinburgh) thought that, taking it all round, iridectomy was by far the best operation, and the results were permanent in the great majority of cases. He much preferred to get an absolutely flat and smooth scar, but, if this were impossible, he thought that Dr. Freeland Fergus's operation would be most useful. Mr. Treacher Collins (London) pointed out that the operation was both a removal of the sclerotic and a cyclo-dialysis, and it was doubtful how much good arose from each part of the operation. Mr. Thomson Henderson discussed the question of the relation between intraocular and intracranial pressure. Professor Fuchs was not satisfied with cyclodialysis, and in some cases he had to do iridectomy for recurrence. He had quite given up the operation. Dr. Freeland Fergus replied, and said that some cases he had cured by trephining without the irido-dialysis. Mr. Treacher Collins opened the discussion on diseases of the lymphoid tissue of the conjunctiva. He pointed out the difficulty in following cases unless attached to an ophthalmic school. All the evidence pointed to the fact that the spread of it was always due to direct infection; the trachoma organism appeared to be a non-purulent one. He described in detail the life-history of the disease, and explained on histological grounds the *rationale* of treatment. He still considered the time-honoured sulphate of copper was the most efficacious means they had as a method of treatment. His experience of *x*-ray treatment was that it was at the present time somewhat uncertain, and radium had not given him much satisfaction. Professor Greef (Berlin) said that no micro-organism had been discovered that caused the disease, and probably it was not an ordinary micro-organism. He described the trachoma bodies he had found and examined. These were constantly present, and were probably a living germ. Mr. A. F. MacCallan (Egypt) gave his experience of trachoma in Egypt. Professor Fuchs (Vienna) had seen the micro-organisms, and they were entirely in the epithelium of the conjunctiva, and he advocated the search for them in doubtful cases. Mr. Sydney Stephenson (London) said that twenty years ago follicular conjunctivitis and trachoma were stages in the same disease. Among 15,000 cases of school children of various classes only 5 per cent. had absolutely healthy conjunctivae. Nearly all showed follicular conjunctivitis, and usually this was associated with enlarged tonsils, adenoids, etc. In this way he came to the conclusion that follicular conjunctivitis was uninfectious, and had nothing to do with trachoma. Mr. Craig (Belfast) said that Ireland was badly affected by trachoma, and this was chiefly due to industrial schools. He advocated legislation and the endeavour to prevent its importation. He still was of opinion that sulphate of copper was the best remedy at present known. Dr. Nelson (Belfast) advocated strict attention to hygiene, good surroundings, and good food. He thought that a regular crusade should be carried out, just as in consumption. Dr. Byers (Montreal) and Dr. Reeve described the legislative procedure in Canada. Mr. Collins and Professor Greef replied.

Friday, July 30th, 1909.

A resolution, calling on the Government to take action to prevent the spread of trachoma, was brought up by the executive of the Section. After discussion by Messrs. Treacher Collins, Storey, Nelson, Pollock, and Harman, the resolution, differently worded, was proposed by Mr. Collins, seconded by Dr. Greene, and carried. Mr. J. H. Tomlinson (Egham) demonstrated his new "scotograph with binocular fixation," an instrument for the detection of loss of sensibility in parts of the retina. Dr. Alexander Fleming (London) demonstrated his modification of Wassermann's serum test for syphilis. Mr. N. Bishop Harman demonstrated his "diaphragm test for binocular vision," and Dr. Pollock and Professor Fuchs commented thereon. The Sections of Ophthalmology and Obstetrics then united, under the presidency of Dr. John Campbell (Belfast), to receive the report of the Ophthalmia Neonatorum Committee. It was presented by Mr. Sydney Stephenson. Dr. Wendell Reber (Philadelphia) said there was a tendency to take the work out of the hands of the doctors, which was a fatal policy. Nurses should not be allowed to administer strong antiseptics. A doctor should be called in to determine their necessity and apply them. Mother and child should never be separated; the most natural feeding was never more necessary than to these affected infants. Dr. George Carpenter (London) agreed in these remarks, and added that compulsory notification was their hope, because thereby they could get immediate treatment of the affected. Dr. Nimmo Walker (Liverpool) objected to the current teaching of obstetricians on the desirability of Credé's method. He detailed their work at the St. Paul's Hospital, Liverpool. Dr. Wallace Henry (Leicester) said notification was impracticable without a definition of what the disease was. Mr. Bishop Harman said their great want was an instructed public opinion; governments and officials would never move except under pressure, it did not pay them. They had to get that pressure applied. Some good had been done in that direction by their work. He said there was no real difficulty in notification. Dr. J. Wharton (Manchester) said voluntary notification had been a brilliant success in his city. Dr. Buist (Dundee) agreed in the advantages of notification, and the smallness and hardship compared with benefit. Dr. J. H. Taylor (Salford) protested against that part of the report which tended to crystallize medical treatment. It was a dangerous precedent. Dr. Cecil Shaw (Belfast) said the objections to notification were the old ones used when diphtheria was under discussion. Dr. Staveley Dick (Manchester) objected to the "Recommendations to Practitioners," their principle was bad, they were not accurate, they would be made a subject of final appeal in cases of action for malpraxis. He moved that they be deleted from the report. Dr. Adam Fulton (Nottingham) seconded this amendment. Dr. Henry and Dr. R. J. Johnstone (Belfast) agreed. Put to the vote the amendment was carried. The amended report was then adopted by the joint meeting of the Sections.

SECTIONS OF PATHOLOGY AND VACCINE THERAPY.

Thursday, July 29th, 1909.

THE Sections of Pathology and Haematology and Vaccine Therapy combined to hold a discussion centring round the early diagnosis and treatment of tuberculosis. It was opened by Professor Calmette (Lille), who from observations on 20,000 cases was able to put forth some valuable conclusions. Early diagnosis, he said, was of the utmost importance in relation to efficacy of treatment, and this should be possible long before clinical or even bacterioscopic manifestations enabled a diagnosis to be made, for the following reasons: (1) The infection was generally localized for a time in the lymph glands, draining the part infected; (2) if the bacilli were not numerous or highly virulent they could be destroyed in these glands; (3) severe lesions resulted from a single infection in bulk or from numerous smaller infections repeated at short intervals. In discussing methods of diagnosing early infection he pointed out that (1) the subcutaneous method was inadvisable on account of the local congestive reaction around the tuberculous foci with the danger of diffusion of bacilli and also because of the uselessness in febrile patients; (2) the cuti-reaction of von Pirquet was not perfect, as it also revealed latent lesions and old calcified and fibrous lesions, and so was only conclusive in patients under three years of age—in 55 per cent. of apparently healthy adults it gave a positive reaction. Hence in positive cases confirmation must be sought in the Wolff-Eisner-Calmette ophthalmo-diagnostic method. This in the apparently healthy only gave a positive reaction in 18 per cent., which corresponds to the average percentage of latent tuberculous patients. He did not think it was of any prognostic importance, nor was it a dangerous method provided that careful precautions were taken to prevent injury to the eye. In only 80 cases out of his 20,000 were there any accidental results. Further anaphylaxis of the conjunctiva did not exist. Often it was necessary to supplement this with other reactions such as the reviviscence and the humoral and phagocytic reactions of various sorts. With all these he thought it ought to be possible to diagnose and isolate the early tuberculous carriers and prevent repeated infections of the same case, and perhaps bring about the entire resorption of bacilli, as was known to occur in bovines. Professor Symmers, in a well-phrased reply, congratulated the assembly on having Dr. Calmette's important work set before it by the author himself. Dr. Paterson (Frimley) dwelt on the importance of preventing autoinoculation, which would occur even whilst the patient was being kept in bed or at stool. Professor Osler thought that all hardened veterans of the pathological world would give a positive Calmette's reaction, but did not state whether he himself or any other veteran had afforded conclusive proof of this statement *in corpore vili*. He thought that a large percentage of school children would react, but a distinction should be drawn between open and closed tuberculosis as regards segregation and the expense attached thereto. Mr. Maynard Smith (London) discussed inoculation treatment of tuberculosis from the surgeon's point of view, and still thought that the extinction of the surgeon was not yet imminent, though he might have to adopt more conservative methods. Dr. Carmalt-Jones gave a critical review of five years' treatment of tuberculosis in the Department of Therapeutic Inoculation at St. Mary's Hospital, with special reference to glandular disease. He submitted that his statistics showed the high value of this method of treatment. Dr. Inman pointed out the importance of the opsonic index in diagnosis before clinical manifestations. Professor McWeeney (Dublin) was in general agreement with Calmette, and had found that v. Pirquet's reaction was given in many non-tuberculous cases. Professor White gave his personal experiences of the initial stages of infection. Dr. Crofton (Sutton Bridge) had successfully tried intravenous injections of iodoform in ether in several cases of tuberculosis. Drs. Houston (Belfast) and Wilcox (London) added their experiences, and Dr. Butler-Harris spoke from the aspect of the general practitioner, concluding that a case of tuberculosis could never be regarded as cured. Professor Wright pointed out that, though more complicated than Calmette's reaction, the opsonic index had some relation to the immunization reaction, so should always replace it where a laboratory was accessible. The ophthalmic reaction was further of danger because of the absorption of a considerable amount of tuberculin from the eye; and, indeed, it had often been followed by a considerable negative phase. He doubted the advisability of continuing to use this method when the most scientific opsonic method of diagnosis was at hand.

SECTION OF PATHOLOGY.

Friday, July 30th, 1909.

PROFESSOR SYMMERS read Dr. Cobbett's (Cambridge) paper on the portals of entry of tubercle bacilli. As

a result of experiments with inert pigment particles, *Bacillus prodigiosus* and *B. tuberculosis*, Dr. Cobbett denied that pigmentation of the lungs was of intestinal origin, and he was able repeatedly to infect the lungs and then the bronchial glands by spraying into the respiratory tract suspensions of both bacilli mentioned. Professor Symmers pointed out that these observations were entirely opposed to the work of Calmette, and of Whitla and Symmers, which tended to show that pulmonary infection was secondary to intestinal infection. Dr. Ford Robertson (Edinburgh) and Dr. Margaret Young (Edinburgh) gave a lantern demonstration of their detailed work on the protozoon origin of tumours. They maintained that tumours were due to organisms of the mycetozoa group, for which a suggestive name would be nucleo-amoebae. By a special ammonium-silver-cyanide method they had followed out all stages of development of this protozoon and had diagrammatized the complete cycle side by side with the cycle of an Haemamoeba. Slides were shown purporting to demonstrate nucleated bodies, some even in conjugation, in Jensen's mouse tumours and human tumours. Further they had cultivated products which fitted into their idea of the complete cycle. Many of the slides, stained by this special method, which was specially stressed, were demonstrated in the adjoining laboratory. Professor McWeeney (Dublin) made an important contribution on the use of coloured media in the detection and differentiation of bacilli of the typho-coli group. With the aid of a watery solution of china green in nutrient agar he had managed almost to completely inhibit *B. coli*, and to obtain a luxuriant growth of *B. typhosus*. These results were most effectively demonstrated on their respective media side by side with cultures on the older media, such as Ludo's and Drigalski's. Professor Benjamin Moore (Liverpool) and Dr. Stenhouse (Liverpool) demonstrated the inhibition of growth of the bacillus of tuberculosis and other organisms in increased percentages of oxygen. Out of thirty-seven different organisms that he experimented with, he obtained definite inhibition only with *B. tuberculosis*, *B. pestis*, and *Staphylococcus pyogenes aureus*. Dr. Wilson (Belfast) described his observations on cases of epidemic cerebro-spinal fever, in whose blood serum he was able to demonstrate specific agglutinins for a non-pathogenic coliform organism isolated from Belfast tap water (*B. aquatelis alkaligenes*), and discussed the question of heterologous agglutinins. His results had led him to conclude that intelligent discrimination should be employed in the diagnosis of disease by the agglutination reaction. Professor McWeeney, in discussing this paper, referred to the analogous reactions observed in swine fever, where specific agglutinins for the coliform organism previously said to be specific for this disease were present, although the disease was now known to be due to an ultramicroscopic organism. He thought that in many infections in man the vital forces were so reduced by the primary infecting agent that organisms ordinarily saprophytic could acquire parasitic properties, with resulting development of specific agglutinins. Dr. Armand Ruffer (Alexandria) and Dr. J. G. Willmore (El Tor) described the varieties of dysentery occurring amongst the El Tor Mussulman pilgrims. They had come to the conclusion that in addition to the purely amoebic dysentery, a large number were due to a bacillus provisionally named "*B. dysentericus* El Tor No. 1." Professor McWeeney congratulated Dr. Willmore on his important contribution; and the meeting concluded with a valedictory address from Dr. Lazarus-Barlow, who referred to the great science of pathology as the Cinderella of medicine, and eagerly anticipated the arrival of the fairy prince.

Section of Pharmacology and Therapeutics.

Thursday, July 29th, 1909.

The meeting of the Pharmacological and Therapeutical Section was continued on Thursday, at 10 a.m., when Professor W. E. Dixon (Cambridge) and Dr. H. H. Dale (London) gave a demonstration of the effect of certain pressor substances in putrid meat, placenta, and ergot on the surviving mammalian heart and uterus. Abelous was the first to find indication of the existence of substances possessing an adrenalin-like action in putrefying meat, and similar substances were later recognized in extracts from the placenta by Professor Dixon and Dr. Taylor. Baiger and Walpole successfully isolated two substances which exerted this adrenalin-like action in a marked degree—that is, isoamylamine and parahydroxylphenylethylamine. They obtained these substances by inoculating a solution of broth containing tyrosin with a culture from human faeces. They came to the conclusion that the activity of the liquid extract of ergot was due almost entirely to the same substances. In the excised heart of a rabbit perfused with Ringer's solution $\frac{1}{2}$ mg. of the active principle injected caused marked acceleration and increased amplitude of beat. It differed from adrenalin in that it could be given by the mouth and in its much more prolonged action. Similar effects were shown on the pregnant uterus of a cat. Professor Benjamin Moore (Liverpool) read a paper upon a new member of the saponin-digitalin group of glucosides, its chemistry and physiological action. He demonstrated upon a surviving mammalian heart its powerful action in slowing the beat and increasing the tone of the heart and the amplitude of the beat. Dr. J. C. McWalter (Dublin), in a paper on the regulation of quack medicine traffic, spoke of the enormous sale of such medicines, amounting to £2,000,000 annually. He suggested methods of controlling the abuse by co-operation with the medical officers of health. In such work the analyses recently published by the British Medical Association were of much value. Dr. F. Charteris (Glasgow) reported the results of extensive trials of the injection of thiosinamin. He had found no benefit clinically, and a large number of estimations showed there was no evidence of any effect on the leucocyte count; this, although the drug had been much praised and extensively recommended. Professor W. E. Dixon (Cambridge) read a paper upon facts and fancies in pharmacology. Tradition still was responsible for many of our formulae. Though opium had no local effect, there were three local applications containing the drug in the *Pharmacopoeia*. Ether and strychnine were not direct cardiac stimulants. Atropin paralysed nerve endings, but had no action on the mammary secretion, which was not under nervous control. He gave many examples of drugs to which certain actions were still erroneously attributed.

Friday, July 30th, 1909.

On the final day of the meeting Dr. H. D. Rolleston (London) opened a discussion on the treatment of oedema. He confined his remarks mainly to the treatment of cardiac and renal oedema. In cardiac dropsy he emphasized the importance of the recumbent posture, of restricted fluids, and of massage, together with certain cardiac tonics, digitalis, caffeine, and its allies diuretin and theobromine. In dropsy of renal origin the etiology was more complicated, and effects were more difficult to estimate. He referred to three cases in which, without any apparent cause, diuresis had suddenly set in and the oedema had disappeared. The great Dr. Johnson of dictionary fame apparently, he remarked, had a similar urinary crisis. It was important to know whether or not the reduction of oedema was always beneficial. He discussed the advisability of limiting the intake of (*a*) fluids, (*b*) of sodium chloride. Sir James Barr (Liverpool), who followed, defined his views as to the etiology of oedema generally. He believed that treatment to be successful must remove the cause. Dr. Lazarus-Barlow held that in the production of oedema, certainly of oedema of passive congestion, the first and most important factors were not mechanical. Primarily, transudation was due to the need of the outside cells for nutrition. Dr. F. Charteris (Glasgow) detailed the practice in Professor Stockman's wards in Glasgow. He believed that caution should be used in the employment of mercury in kidney disease. Symptoms of salivation, etc., were very readily pro-

duced. Sir Lauder Brunton referred to Ranvier's experiment, in which oedema did not occur, after ligature of the femoral vein in a cat, even when the motor nerves were also cut, but did occur on division of the sympathetic nerves. This nervous element was well shown in angio-neurotic oedema. He had produced oedema by injection of antistreptococcal serum, and he believed that the toxins here concerned had an action similar to that of the toxins of renal disease. Dr. H. C. Cameron (London) thought that too little attention had been paid to the "salt-free" treatment. The curve of the body weight of the patient had been proved to follow very closely the proportion of salt retained, as shown by estimation of the sodium chloride in the food, sweat, urine, and faeces. In certain cases, where the heart and lungs were hampered by excessive oedema, it should be tried. Dr. Sillar (Edinburgh) believed that the cause of some cases of oedema was the absorption of toxic products from the intestine. In this respect the action was comparable to that of other poisons which facilitate permeation. Professor Stockman (Glasgow), in the absence of Dr. Rolleston, replied. Dr. Robert May (Belfast) read a paper upon the action of cresotinic and toluic acids in acute rheumatism. Their composition closely resembled salicylic acid, and their pharmacological action was almost identical. They were, however, distinctly less toxic. Earlier workers had used impure preparations. Sir Lauder Brunton congratulated the reader of the paper. It was a valuable contribution to the relationship between chemical constitution and physiological action.

SECTION OF PSYCHOLOGICAL MEDICINE.

Thursday, July 29th, 1909.

IN his prefatory remarks to his paper on the present position of applied psychology in medicine, which opened the second meeting of this Section, Dr. Schofield said he wished it to be clearly understood that he did not limit the range of psycho-therapeutics to the treatment of mental diseases, but wished to emphasize rather the need for the special education of all medical men as an indispensable part of their curriculum in the psychic treatment of all diseases, of whatever kind. Defining psycho-therapeutics as "the power of the mind in medicine," the speaker discussed the principal elements which entered into the relations existing between the physician and his patient under the heads of the reason, emotions, and will of the physician, and the influences upon the reason, emotions, and will of the patient; the need for an educated guidance of the patient in these matters, and the beneficial effects which might accrue to the patient by a proper choice and disposal of surroundings. Finally, he submitted that it was high time that the study of psychic methods of treatment should form part of every system of medical education. Treatment by suggestion was mentioned incidentally, the "power of the mind over the body" tacitly assumed, and the influence of the will in averting or postponing death affirmed; but, although the study on a scientific basis of psycho-therapeutics was mentioned on several occasions, no hint of such scientific study was afforded by the paper, which consisted mainly of vague generalities upon the undoubted benefits to the patients which follow suitable suggestions by the physician—confidence in the treatment and the will to get better. Dr. Mercier's paper on somatic delusions and local lesions was then read, in the absence of the author, by Dr. W. S. Smyth. The paper consisted of a description of a case of a man with a persistent delusion that his bowels were stopped, who refused food in consequence, although his bowels were moved several times a week. He also believed that he had been ravished per rectum by a Frenchman, this also, for sufficient reasons, being deemed to be a delusion. After an illness of over two years the patient died, the *post-mortem* examination revealing extensive tuberculous disease of the lungs and perforating ulceration of the small intestine, with terminal peritonitis. The author discussed the various possible hypotheses which might be advanced to explain the connexion between the bowel disease and the delusions, and in the end inclined to the view that the central cortex representing the bowel was first affected, the metabolism of the bowel in consequence interfered with, and the resistance of the bowel so lowered that it easily became tuberculous. The delusions were thus not secondary to the local lesion; but both the physical disease in the bowel and the delusions arose from the central disorder in the assumed cortical centre in which the bowel is represented, and from which its metabolism is governed. After a brief discussion by Dr. Dawson, a resolution of regret at the cause of Dr. Mercier's absence was proposed by Dr. Greenlees and carried by the meeting. An extremely interesting paper by Dr. Shuttleworth on Mongolian imbecility, based on 350 cases, mostly observed by the reader, was then read. After a brief account of the bibliography of the subject and an anatomical description of the type of imbecility, Dr. Shuttleworth considered, first, etiology, that is, heredity, and such factors as parental alcoholism and syphilis, and came to the conclusion that Mongolian imbeciles were exhaustion products, more than one-half of all cases in institutions being the last-born of long families, and in a large proportion of all cases the children of mothers already old in the child-bearing period. Dr. Shuttleworth's paper, which was illustrated by numerous excellent photographs, was followed with great interest, as were also the remarks of Dr. Langdon-Down, who spoke next on some points not touched upon by Dr. Shuttleworth, including the hand shape and markings of Mongolian imbeciles, illustrated by hand-prints. After Dr. Caldecott had commented upon the brief span of life of Mongolian imbeciles, rarely exceeding twenty years; the valuelessness of thyroid treatment, and their invariable proneness to tuberculous disease, necropsies disclosing tuberculous lesions in 100 per cent., the meeting terminated.

Friday, July 30th, 1909.

The last day of this Section was devoted to a consideration of the Report of the Royal Commission on the Feeble-minded. The discussion was opened by Dr. W. R. Dawson of Dublin, and the Section was honoured by the presence of Her Excellency the Countess of Aberdeen. After a general survey of the principles laid down by the Royal Commission, and after suggesting that, so far as Ireland was concerned, it would be well to restrict the powers of the local authorities by turning the asylum service into a national service on the lines recommended for the Irish Poor Law Service by the recent Viceregal Commission, Dr. Dawson proceeded to the discussion of the detailed recommendations of the Royal Commissioners. With regard to the three methods of dealing with defective persons by supervision, certification, and detention, the speaker failed to see what good could be done by the first two alone. With regard to classification, he did not quarrel with the disuse of the terms "lunatic" and "asylum," though any benefit accruing from the change could be only temporary, and the distinction between "persons of unsound mind" and "persons mentally infirm" seemed to him devoid of utility. Whilst in general agreement with the recommendations of the Commission, Dr. Dawson agreed with Commissioner Dunlop that compulsory notification, except where public assistance was required, was undesirable, and objected also, where Ireland was concerned, to the retention of the order for reception by a judicial authority, this being stigmatized by the speaker as an unwarrantable intrusion. Also his investigations in Dublin had convinced him that the establishment of special schools for mentally defective children was an impossibility, and that the provision of special classes would be much better. Further, he considered that the whole system should be supplemented by regulations dealing with inebriates who were not mentally defective, and lastly he thought that the recommendations of the Commissioners on the matter of family care were half-hearted and insufficiently definite, and that no system of provision for the

mentally defective could be complete without the inclusion of that form of treatment which was at once simple, easily provided, and inexpensive. Dr. Shuttleworth then gave the meeting the benefit of his long experience with mental aments, and in particular pointed out that any scheme of compulsory notification as applied to the young child would be difficult, likely to arouse much opposition in the parents of the children, would throw a great responsibility on the certifying officers, and would permanently label many who might afterwards prove to be wrongly labelled as outcasts. Dr. Maguire and Dr. MacCormac both referred to the need for some provision being made for the early treatment of cases of incipient insanity and of early juvenile imbecility, and Mr. Fagan, Inspector of Reformatories and Industrial Schools in Ireland, voiced the general feeling of all speakers at the meeting that compulsory notification was inadvisable, and further that, in his opinion, it was unwise to separate feeble-minded children from their fellows at too early a stage, as he found that they derived benefit from mingling with normal children, when the feeble-minded bore only a small proportion to the normal children. Dr. Caldecott discussed the recommendations of the Commissioners from the financial standpoint, and affirmed that these recommendations, if carried out, would bear very hardly on charitable institutions by converting voluntary subscriptions into public contributions. He considered also that the Commission's estimate of the increased expenditure which would follow the adoption of their scheme, of £500,000 a year, would turn out to be nearer £1,500,000. Dr. Dawson then briefly spoke on the several points raised during the discussion, and in particular laid stress on the almost entire lack of provision for feeble-minded children in Ireland, there being only one institution, the Stewart Hospital for Imbeciles, with 100 beds, while it was estimated that there were 10,000 defective children in the country. The customary votes of thanks to the President having been passed, the proceedings then terminated.

SECTION OF SURGERY.

Thursday, July 29th, 1909.

A DISCUSSION on modern methods of treatment of tuberculous disease of joints was opened by Sir William Macewen, who laid it down as an essential preliminary of treatment that a clear idea of the pathology and of the stage of the disease should be obtained. Only in the earliest stages, when tubercles were still discrete, blood vessels dilated, and no tissue actually dead, could cure be effected by treatment via the blood stream. When tissues still living were engaged in the endeavour to create a barrier to stop the progress of the disease, or to absorb dead tissue and bacilli, then was the time for chemical agents and active surgical intervention. The important point was to attack the disease whilst still limited to the bone and prevent its extension to the synovial membrane. The greatest reliance was to be placed on a proper use of iodoform emulsion injected into the actual focus of disease. The injection of sinuses with bismuth was useful both for diagnosis and treatment. Bier's treatment, unaided, had not fulfilled in this country the expectations raised by its success abroad. Massage used with iodoform was often very useful. In final stages, excisions might be practised with the certainty of good functional results in most joints; they should always be "intracapsular." Mr. Robert Jones emphasized the divergence to be observed between treatment for adults and children. He thought tuberculin valuable not only as a means of very early diagnosis but also of treatment. Limitation of movement and rigidity was, he thought, the most valuable early clinical sign. He described criteria for deciding the proper time for cessation of fixation treatment. Abscesses should, he felt, be treated in the most conservative way. Deformity, except in the case of the spine, should be reduced regardless of the stage of the disease. Professor Sonnenburg related his procedure in treating affected joints with new tuberculin. Mr. A. H. Tubby drew attention to paraarticular foci and the necessity for operative eradication. Mr. Crawford Renton believed every palliative method should be given a chance, but that excision should not be indefinitely postponed, especially in the case of the elbow. Mr. Ward Cousins emphasized the importance of eliminating the bacillus. Mr. Maynard Smith gave the results of treatment of tuberculous joint disease at St. Mary's Hospital by the opsonic method. Mr. Rushton Parker gave some historical reminiscences of the progress of treatment. Mr. Cathcart, whilst agreeing that iodoform emulsion was most useful, believed that excisions were often required. He thought much was to be hoped from tuberculin as a therapeutic agent. In the course of his reply, Sir William Macewen agreed that Calmette's test was safe and valuable. He had also used the Pirquet reaction. *X* rays were certainly valuable. He demonstrated by numerous photographs the excellent functional results obtained after excisions. Cases of interest were demonstrated to the members of the Section by Mr. Howard Stevenson and Mr. A. B. Mitchell.

Friday, July 30th, 1909.

Mr. Syme of Melbourne read a paper on the diagnosis and treatment of some of the rarer forms of echinococcus cyst. With regard to lung hydatids, he said that in the case of unruptured cysts the *x*-ray pictures were typical, but with ruptured cysts this means of diagnosis was less useful, and the condition was often mistaken for pulmonary tuberculosis. The character of the sputa, however, generally enabled the careful and constant observer to recognize the actual lesion. In bone the exogenous form of development was common in the cancellous tissue, and, probably as a result of the pressure, the formation of scolices was prolific. In some cases eosinophilia was marked, about 9 per cent. of eosinophiles being not uncommon. He referred to the precipitin reaction, but said that in the Melbourne Hospital they had always got negative results, which were of little value. He thought "marsupialization" the best treatment; where lung and liver were simultaneously affected the liver cyst—the primary, that is—should be evacuated per abdomen. Cysts in the spleen might be evacuated and the organ dropped back into the peritoneal cavity. He had no experience of the closure of suppurating cysts by suture; in bone, thorough and repeated gouging and scraping generally led to successful eradication. Mr. Ward Cousins referred to very large hepatic cysts which might be mistaken for ovarian, especially if sterile, and also to cases in which chronic changes obscured the true character and origin of the cysts. Mr. Freyer exhibited a series of prostates removed from octogenarians, and also some of very large size, the largest weighing 17 oz. He presented the final statistics of his 644 operations to date. The total mortality was 6 per cent.; the average age 69, and the average prostatic weight 2½ oz. In 114 instances calculi were present. In reply to the President, Mr. Freyer said that he now only left in the tube for from four to ten days, and that if at the expiration of that time catheters were regularly passed, no constriction took place at the opening of the bladder cavity into that from which the gland had been enucleated. He only made use of initial irrigation when uraemic symptoms were present, and it was generally wise to drain the bladder suprapubically for ten days before enucleating the prostate in these cases. Dr. Hort read a paper on the diagnostic value of estimations of the antitryptic content of the serum in cases of malignant growth. Mr. Mitchell detailed 16 cases of operation for perforated duodenal ulcer with 16 recoveries. He drew attention to the undue stress laid upon shock as a sign of perforation, and emphasized the value of rigidity of the muscles as an early feature. He explained the constant absence of considerable extravasation as due to reflex contraction of the pylorus. He had made use of gastro-jejunostomy, in addition to simple suture of the ulcer, in 7 cases without a fatality. Mr. Ward Cousins thought the absence of shock in visceral perforation was to be explained by

the quantity of fluid poured out into the peritoneum and thence absorbed. Mr. Thelwall Thomas advocated early operation and anaesthesia with ether by the open method. In the course of his reply Mr. Mitchell said an additional danger of morphine was the relaxation of the pylorus induced. Mr. Edington discussed the question of resection of intestine in various conditions. Mr. Leedham-Green gave his experiences of a hundred consecutive cases of scopolamine-morphine narcosis, describing his routine, and characterizing the method as ideal for the patient, in contrast to the spinal method, which, whilst perhaps ideal for the surgeon, had serious drawbacks for the patient. The advantages claimed for this method were that the patient was spared preliminary nervous tension; full narcosis was early and quickly attained; the amount of anaesthetic necessary was lessened by at least a half; complete muscular relaxation could be secured; the secretion of mucus was much diminished, so that ether could be given easily and safely; post-operative pneumonia could be avoided; the operation was followed by long and peaceful sleep of four to six hours' duration; there was almost complete absence of post-anaesthetic vomiting; and, finally, there was plenty of evidence to show that, as compared with simple inhalation narcosis, scopolamine-morphine was safer.

SECTION OF TROPICAL DISEASES.

Thursday, July 29th, 1909.

MR. J. CANTLIE (London) opened a discussion on the treatment of chronic recurrent dysentery, with special reference to the possibilities of surgical treatment. He pointed out the many terms applied to intestinal flux associated with mucus in the faeces, and with occasional attacks of fever accompanied by blood in the stools. He considered that in the chronic forms of the disease a stenosis at the junction of the sigmoid and rectum (the sigmo-rectal pylorus) was to be met with in the majority of cases, and the treatment resolved itself in the means of dealing with this lesion and its consequences. He reviewed treatment by diet, by drugs, by enemata, and by surgical operations. In lesions limited to the junction of the rectum and sigmoid, when other means failed he recommended opening the upper part of sigmoid. When the disease extended further, he recommended washing out the bowel from the appendix, and when this proved insufficient, opening the ascending colon in preference to the caecum. A discussion followed, in which the following took part: J. L. Maxwell (Formosa), W. Carnegie Brown (London), Allan H. Hanley, C.M.G. (Dublin), R. A. Carter (British Guiana), J. Herbert Sanders (Hong Kong), Captain Gordon Tucker, I.M.S., Fleet Surgeon Lloyd Thomas, R.N., and the President, C. W. Daniels (London). A paper was communicated by H. E. Ozzard (British Guiana) on the life-history of *Ankylostoma duodenale*. He had cultivated the ankylostoma outside the human body, and having satisfied himself that this could be done, concluded that the *Ankylostoma duodenale* must be heterogenetic. The President (C. W. Daniels) discussed the paper.

Friday, July 30th, 1909.

Dr. W. Carnegie Brown (London) opened a discussion on feeding and treatment of children in the tropics. He stated that, although reliable vital statistics from tropical countries were unattainable, they followed the general rules that obtain in European countries where more carefully prepared returns are given. Amongst well cared for children, whether European or native, the death-rate was low in the tropics as in temperate climates; whilst in the tropics, amongst the lowest classes of natives whose children were badly nourished, the infant mortality might reach 50 or 60 per cent. This terrible loss of infant life was almost entirely due to gastro-intestinal disorders which were directly caused by the want of fresh and nutritious milk. He drew attention to a fact at times observed among European women; previously delicate, they improved in health whilst breast-feeding their infants. He compared the milk of the cow, the goat, and the buffalo as substitutes for breast milk, and discussed the uses of condensed and preserved milks. The main disorders of early life due to tetanus neonatorum, gastro-intestinal affections, entozoa, dysentery, malaria, yaws, and enlargements of the liver and spleen, were dealt with in detail. The speaker considered it more than doubtful whether a white population could ever be successfully reared in the tropics. The following took part in the discussion: Lieutenant-Colonel Andrew Deane, I.M.S., J. L. Maxwell (Formosa), Surgeon-General W. R. Browne, C.I.E. (Madras), Major J. Ritchie, R.A.M.C., J. Cantlie (London), Stuart Brooke (India), Professor Hellier (Leeds), Captain T. H. Campbell, R.A.M.C., Robert Aird (Hankow), C. W. Daniels (London). The meeting was well attended, and a cordial vote of thanks was recorded to the President, Vice-Presidents, and the Secretaries of the Section.

LITERARY NOTES.

PROFESSOR OSLER has a subject entirely to his taste in the Linacre Lecture delivered by him at St. John's College, Cambridge, in 1908, and reprinted at the Cambridge University Press. Thomas Linacre appeals to him not only as a physician but as a humanist. As every one knows, Linacre was the founder of the Royal College of Physicians of London. He was born at Canterbury in 1460, and educated at Oxford. He then went to Italy, where he was one of the earliest English students who sought at Padua the medical education they could not get at home. Linacre also studied Greek at Florence under Politian and Demetrius Chalcondyles, and he transcribed Greek manuscripts in the Vatican Library. He was, indeed, all his life more a scholar than a physician. Early in the sixteenth century he was appointed physician to Henry VIII, who himself was, according to Froude, one of the best physicians in his kingdom. At any rate, he took sufficient interest in the subject to favour Linacre's scheme of founding a college. Linacre was a friend of Thomas More and all the scholars of a court which Erasmus describes as "less a palace than an academy of learning." He translated several of Galen's works, and was the author of a Latin grammar which was for a long time an accepted authority, especially on the Continent. In his later years Linacre entered into Holy Orders, and held a number of benefices. He died of stone in the bladder in 1524. Professor Osler thinks that Linacre may have been the scholar who gave Browning the idea of *The Grammarian's Funeral*. At any rate the description would fit him:

> Back to his book then; deeper drooped his head;
> Calculus racked him
> Leaden before, his eyes grew dross of lead;
> Tussis attacked him.
> "Now, master, take a little rest,—not he!"
> Not a whit troubled
> Back to his studies fresher than at first,
> Fierce as a dragon.
>
> So with the throttling hands of Death at strife,
> Ground he at grammar:
> Still, through the rattle, parts of speech were rife
> While he could stammer.
> He settled Hoti's business—let it be!
> Properly based Oun,
> Gave us the doctrine of the enclitic De,
> Dead from the waist down.

Of the many foundations associated with Linacre's name, a full account is given by Professor Osler, whose booklet, illustrated by reproductions of the title pages of several of Linacre's works, is interesting alike to doctors and to scholars.

Dr. Henry Barnes (Carlisle) writes: As supplementary to your notice of Dr. Homan's paper on St. Luke (see JOURNAL, July 31st, p. 274), I venture to send you a few additional observations, as any facts or comments bearing on the literary or medical character of the author of the third gospel will probably be welcome to your readers. There is reason to believe that St. Luke, who is affectionately called the "beloved physician" by St. Paul (Col. iv, 14), was an Asiatic Greek. He was born at Antioch in Syria, and his writings bear clear evidence that he had received an education much superior to that of the other evangelists. Instances are given by Professor

Harnack of St. Luke's literary skill, the dramatic pith and power of his style, and the poetic richness of his imagery. Reference should also be made, as Bishop Goodwin points out, that he has special claims to be regarded as a historian in the modern sense of the title. He is sensible, for example, of the importance of dates and of giving the means of verifying them. In his first chapter he gives a careful note of time: "There was in the days of Herod, the King of Judaea" (St. Luke i, 5), and again, in the second chapter:

> It came to pass in those days that there went out a decree from Caesar Augustus that all the world should be taxed. And this decree was first made when Cyrenius was Governor of Syria.

This statement has aroused much controversy, an account of which will be found in *Smith's Dictionary of the Bible*, under the heading of "Cyrenius," and it is satisfactory to know that recent investigations establish the accuracy of St. Luke on this point. In the third chapter we have another careful note of time:

> In the fifteenth year of the reign of Tiberius Caesar, Pontius Pilate being governor of Judaea, and Herod being tetrarch of Galilee, and his brother Philip tetrarch of Ituraea and of the region of Trachonitis, and Lysanias the tetrarch of Abilene, Annas and Caiaphas being the high priests, the word of God came unto John the son of Zacharias in the wilderness.

In this instance the mention of two high priests is contrary to the principle that there could be but one, but there is abundant evidence to show that Annas had been irregularly deprived by the civil power and Caiaphas substituted for him. Many other instances of St. Luke's historical accuracy might be given, but these must suffice. With regard to the medical language of St. Luke as a proof that the writer was a medical man, much has been written by several writers before the matter was taken up and discussed by Professor Harnack. In the *Gentleman's Magazine* for June, 1841, Mr. J. K. Walker calls special attention to the medical language used by St. Luke in his account of the miracles, and points out that not only is he more circumstantial in his narrative of those miracles which relate to the healing art than the other evangelists, but there is one recorded by him—that of raising the widow of Nain's son—not to be found in any other part of the four Gospels. When he mentions diseases, or their cure, he selects such words as none but a professional man would use, and shows some previous acquaintance with Greek writers. A few examples may be given. The word ὑδρωπικός, applied to the man who had the dropsy, occurs only in St. Luke. In speaking of one afflicted with palsy, St. Luke uses the word παραλελυμενος, whereas the other evangelists use the word παραλυτικός, which is never used by Greek medical writers. The medical term, παραξυσμος, appears in St. Luke, but not in the other Gospels. In speaking of Simon's wife's mother, who was taken with a great fever (St. Luke iv, 38), he uses the term συνεχομενη in the same sense as the Greek writers. In 1882, the Rev. W. K. Hobart, LL.D., ex-Scholar of Trinity College, Dublin, published an exhaustive analysis of St. Luke's writings,* in which he gives a list of some four hundred words which are rather peculiar to St. Luke, or which, though not peculiar, are yet for the most part more frequently employed by him than by any other New Testament writer. The subject is also discussed by Mr. James Smith in his *Voyage and Shipwreck of St. Paul.* In his *Foundations of the Creed*, Bishop Goodwin remarks (p. 112) that it is not merely the use of medical terms, but the manner of dealing with medical subjects which brings home to the mind the fact that the third Gospel was written by a physician. Take one instance: St. Mark tells us (chap. v) that the woman who had an issue of blood twelve years *had suffered many things of many physicians, and had spent all that she had, and was nothing bettered, but rather grew worse.* Compare this severe account of medical treatment with the corresponding passage in St. Luke (chap. viii), who speaks of *a woman having an issue of blood twelve years, which had spent all her money on physicians, neither could be healed of any.* "The same story precisely, but very differently told. St. Mark was not a physician: St. Luke was." It is not without significance that in alluding to the expense incurred by the woman different words should be used by the two evangelists. St. Luke uses the word προσαναλωσασα, derived from the verb signifying to expend, and St. Mark uses δαπανησασα, a word which is more applicable to wasting or spending in a riotous and luxurious manner, and this is the word used by St. Luke in the case of the prodigal son.

* *The Medical Language of St. Luke, a proof from Internal Evidence that the Gospel according to St. Luke and the Acts of the Apostles were written by the same person, and that the Writer was a Medical Man.*

Medical News.

DR. DUDLEY BUXTON has been appointed to the newly instituted chair of anaesthetics at the Royal Dental Hospital of London in Leicester Square.

FRED. HIBBERT WESTMACOTT, F.R.C.S., from Honorary Associate, has been appointed a Knight of Grace of the Order of the Hospital of St. John of Jerusalem.

DR. ARMAUER HANSEN, of Bergen, the discoverer of the leprosy bacillus, has been elected a foreign associate of the Paris Academy of Medicine. At the same sitting a like distinction was conferred on Professor Morisani, of Naples.

UNDER the title of "L'Esculape" a medico-artistic society has recently been founded in Paris. It is organizing an exhibition of painting, sculpture, engraving, and decorative art for November next. Literary recitations and dramatic and musical sketches will be included in the programme. The honorary committee consists of: Drs. Garrel and Widal, of the Academy of Medicine; MM. Gilbert, F. Henneguy, and Edmond Perrier, members of the Institute of France; Dr. Marcel Labbé, *professeur agrégé* in the Paris Faculty of Medicine. The following are the members of the committee: President, Dr. F. Bezançon, *professeur agrégé*; Vice-Presidents, Drs. Marx (Physician to St. Lazare), Barbillon, and Delmond-Berret; Secretaries, Drs. P. Rabier and Fr. Déherain; Treasurers, Drs. R. Sassier, Fr. Ferrand, Cabanès (editor of the *Chronique Médicale*), Cocquelet, and Léon Petit.

A QUARTERLY court of the directors of the Society for Relief of Widows and Orphans of Medical Men was held on July 14th, Dr. Blandford, president, in the chair. Twenty-one directors were present. The death of a member of the society was reported, and seven new members elected. The sum of £1,255 was voted for paying the half-yearly grants to the forty-eight widows and thirteen orphans on the books of the society. The widow of one of the members applied for relief; her husband, owing to ill health, had been unable to make any provision for his widow, and a grant at the rate of £50 per annum was voted. The society only grants relief to the widows and orphans of deceased members. Membership is open to any registered medical practitioner who at the time of his election is resident within a twenty-mile radius of Charing Cross; the subscription is two guineas a year, or a member may become a life member by paying a sum fixed by the by-laws of the society. The invested funds now amount to over £100,000. Application forms for membership and full particulars may be obtained by applying to the secretary at the offices of the society, 11, Chandos Street, Cavendish Square, W. The next election takes place on October 13th. Application forms must reach the secretary on or before September 22nd.

OVER forty years ago, in September, 1865, a statue by Noble was erected in the Ranelagh Gardens, Chelsea Hospital, in memory of Sir James McGrigor, the first Director-General of the Army Medical Department. It was felt that the new Royal Army Medical College in Grosvenor Road would be a more fitting place for this memorial of an officer whose career was so closely and gloriously associated with the army and the advancement of medical science. Accordingly permission having been obtained from the authorities, the statue has been re-erected on a site in the grounds of the College on the north-east side facing the Tate Gallery. The cost has been defrayed by the officers of the Royal Army Medical Corps. Sir James McGrigor occupied very much the same position on the staff of the Duke of Wellington as that held by Barron Larrey on that of Napoleon, and as the statue of the famous surgeon, who was described by the Emperor as the most virtuous man he had ever known, adorns the grounds of the Val-de-Grâce (the army medical school in Paris), so now, after a lapse of many years, the monument of his British compeer has found a fitting place in the grounds of the Royal Army Medical College, London. Sir James McGrigor was a native of Aberdeen, and a memorial of him in the form of an obelisk of Peterhead polished granite was removed a few years ago from the quadrangle of Marischal College to the Duthie Park, Aberdeen.

British Medical Journal.

SATURDAY, AUGUST 7th, 1909.

THE ADDRESS IN OBSTETRICS.

It is natural that apostles and enthusiasts should magnify their office—indeed it is a necessary condition for success. Sir John Byers cannot be accused of belittling either the importance of obstetrics, the qualifications necessary for success in that art, or the part taken by Irish institutions in the progress of midwifery. A deceased surgeon of great eminence used to say that when the surgeon was called to the parturient woman her danger began. Before the time of Semmelweis this was literally correct. It is true, as Sir John Byers said, that the practitioner of midwifery has to think of the well-being of two human lives, and that either of them may suffer from something which requires the widest knowledge and the highest skill to discover, prevent, or cure. But such cases are exceedingly rare. In the enormous majority of labours, all that is wanted is that the patient shall be made clean and kept clean, and that the process of natural delivery shall not be interfered with. Midwifery is in truth a limited department of preventive medicine.

Sir John Byers's address consists of two parts. The first might well have been entitled, "*Venite exultemus Lucinae*"; or, with a local application, "*Venite exultemus Rotundae.*" Sir John exults, and with good reason, on the practical extinction of puerperal sepsis. He referred to the address in obstetrics delivered in 1884 by the late Dr. George H. Kidd, ex-Master of the Coombe Lying-in Hospital. This distinguished man was, however, behind his time in the matter of antiseptic midwifery, for he said: "The history of great hospitals, such as that of "Dublin and Vienna, shows that puerperal fever will "prevail and cause sad mortality at times, and "disappear again, and that the conditions governing "its movements have not yet been discovered." Dr. Kidd was not happy in his choice of a hospital to illustrate this belief; for it was in the Vienna clinic that Semmelweis demonstrated that puerperal fever could be prevented. It seems as if in 1884 he were not acquainted with the *Traité de l'art des accouchements* of Tarnier and Chantreuil, the first volume of which had been published in 1882. These authors there stated: "In France, in England, in Germany, in "Russia, in Italy, in Switzerland, in a word, in every "country, progress is accentuated; everywhere the "mortality and morbidity of lying-in women diminish "from day to day." This statement remains true to-day. Puerperal infection is not yet extinct; but those who administer the Midwives Act are steadily wiping out one after another from the midwives' roll the dirty old women of the Mrs. Gamp type; and the old doctors who know not antiseptics and scorn what is new to them, are yearly joining the choir invisible, and are being replaced by younger men, who recognize in Lord Lister one to whom every medical knee should bow. Sir John Byers expresses his regret that "the various maternity hospitals are not agreed "as to the physical indications of puerperal "septic morbidity." He quotes the views of a Committee of the British Medical Association, which he calls the "British Medical Association "standard." He quotes also what he terms the "Rotunda Hospital standard," which represents the opinion of the Master of the Rotunda. The great Napoleon has somewhere been reported to have said that the worst general that ever existed was better than a council of war. A widely different but very sensible Englishman said that the best number for a committee was three, of whom two did not attend. We also in practical matters prefer the opinion of a competent man with responsibility upon his shoulders to the resolutions of any committee. We may remark, however, that as in 1882 the Coombe Lying-in Hospital was behind Paris, so the Rotunda was behind London; for Sir John Byers tells us that the clinical thermometer was first introduced into the Rotunda Hospital in 1882. In the London teaching hospitals the clinical thermometer was used in the later Sixties, and the English translation of Wunderlich's *Clinical Thermometry* was published in 1871. In 1882 the amount of morbidity in the Rotunda made known by the thermometer was 50 per cent. In 1907–8 it had been reduced to 3.64 per cent., a result on which the hospital is to be congratulated. Sir John Byers attributes this achievement, in the first place, to the recognition of the fact that in 75 per cent. of labours there is no need to meddle; they will safely finish themselves. He does not push this principle to the length that some have done and say that labour should be conducted without vaginal examination. Without vaginal examination how can disease in the passage be discovered? The second cause of improvement is the adoption of Listerian principles. The third is the limitation of vaginal examinations to the fewest possible number. The fourth and last improvement is the immediate suture of *any* laceration occurring during the process of labour (the italics are ours). Is not this statement somewhat too sweeping? In the first place, some laceration of the cervix, and of the vaginal orifice, takes place in every first labour, as Matthews Duncan pointed out. Its frequency is illustrated by the importance attached by nurses to what is called the "show" as an indication that labour has begun. The "show" means that there has been slight laceration of the cervical mucous membrane. Lacerations, if not too extensive, are beneficial, in shortening the duration of subsequent labours. The precept to suture *any* laceration immediately means an anaesthetic in every case of labour; for a practitioner who should suture the perineum in every case without an anaesthetic would in a year or two find his occupation in this particular practice gone. And this means that another practitioner must be sent for, for one man cannot satisfactorily both anaesthetize and stitch. An anaesthetist means, of course, another fee and a slight additional danger. Suture of a torn cervix is not always easy; an ill-applied suture may include the ureter, or may lead to retention of discharge, and consequent sapraemia. These are reasons which make some people think it wiser not to try to sew up tears in the cervix immediately after delivery. Sir John Byers impresses on practitioners some home-truths occasionally forgotten by extremists: for instance, that it is possible for sterilized india-rubber gloves to convey pathogenic microbes from the vulva into the uterus; and that febrile illness during childbed is not necessarily of septic origin, and, if of septic origin, that it does not necessarily follow that the patient was infected during delivery.

Sir John Byers tells us that "the whole tendency of "our operative measures now is to avoid craniotomy "in a living child." This is the principle that now directs the practice in most lying-in hospitals. But does it do so in private practice? The latest figures that we know of to illustrate the risk the mother runs in Caesarean section (those of Munro Kerr) show a maternal mortality of 8 per cent. Till the mortality of Caesarean section has been brought down much lower than it is at present, we think the time is not ripe for the general practitioner to send his cephalotribe to a museum.

The second part of the address is entitled "The "Future Development of Obstetrics." Like all specialists, Sir John Byers wants more and more practical training for the student and the pupil midwife. He is in hearty agreement with the General Medical Council, which is trying to enforce upon the London medical student a kind of training which the London medical schools, with one exception, cannot give. The University of Cambridge has swallowed whole the proposals of the General Medical Council; with the result, so far as we can see, that the Cambridge student will have to go out of England to learn midwifery.

The two London Royal Colleges have so far declined to act on the resolutions of the General Medical Council. There is one point of view from which Sir John's practical proposals are wholly admirable. We should like to see practical training replace the acquisition of verbal information, which can be written upon paper and therefore tested by examiners who know nothing more about the candidate. The best education is that which produces a person who can *do*, rather than one who only *knows* about something. The one is education, the other only information.

With these general propositions as to the advantages of practical training hardly any one will be found to disagree. But when we come to the putting into practice of these excellent principles we find that the reformer knocks against any number of hard economic snags. The benefits conferred upon the poor by the outdoor maternity departments of our large teaching hospitals make no large calls upon the funds of those hospitals. But the building of lying-in hospitals or the provision of lying-in wards in our great teaching hospitals and the maintenance thereof involve great expense. The midwife, if Sir John Byers can have his way, must pass a preliminary examination in "suitable general education," have a training in medical and surgical nursing, and then a year's midwifery training. He does not specify what is the "suitable" general education; but we presume he wishes to raise the average intelligence and knowledge of the women who practise midwifery. There are people, of whom Mr. Harold Gorst not long ago made himself the spokesman, who regard modern so-called education as a "curse," and who, if they had to pick out women to serve as nurses and midwives, would rather have those whose intelligence had not been crushed and their powers of observation and action blunted and weakened by being forced at an early age to learn by heart scraps of useless information and unintelligible verbal formulae. These views are no doubt extreme, but that there is an element of truth in them will scarcely be denied by any one of practical experience.

But supposing this highly-trained midwife is obtained, who is to pay her adequately for her services? She will want a larger fee than the less educated woman who at present gets on the midwives' roll. Those who want to screw the standard up and up should remember that no law can ever prevent one woman from rendering service to another during childbirth It can forbid a woman to call herself a midwife, and it can make a pecuniary consideration irrecoverable at law; but if a woman about to have a baby prefers to trust to the attention of a humble "friend" who is not a midwife, and does not call herself one, rather than pay the fee of a highly-trained woman on the midwives' roll, the law can never prevent this.

Sir John Byers quotes with approval a speech of the President of the Local Government Board to the effect that it was the business of every employer of labour, of every husband and wife, and of every department and authority concerned in the future of the race, to see that the prenatal conditions of the child were vastly improved. With this we all agree. But how? That is the question. Sir John Byers hopes much from "babies' clubs," institutes similar to the "consultations for nurslings" established in Paris by Pierre Budin. These "babies' clubs" both educate the mothers and ensure pure milk for the babies. He asks attention to the amount of preventable blindness produced by ophthalmia neonatorum, and he would like these cases early removed to some "hospital or institution." Yes; but by whom, and at whose expense?

In his concluding paragraph, Sir John Byers specifies some of the yet unsolved problems of obstetric medicine, and he winds up with a quotation which expresses in melodious verse the cheery optimism which is the dominant note of the address. We thank him heartily for it, and would add as our comment, *Floreat Johannes Byers, floreat, florebit!*

CROWNER'S QUEST LAW.

Not a few cases reported in the British Medical Journal during the last few years have shown that the law governing the practice of coroners in the holding of inquests is not very clear, or at any rate that it is variously interpreted, and we have on several occasions felt it our duty to call attention to what seemed to us instances of abuse of power on the part of certain individuals dressed in the authority of that ancient office. The manner in which one coroner in particular conducted inquests has more than once been brought to the notice of the Lord Chancellor, but without directly producing any particular effect. That these remonstrances, however, have not been altogether unheeded is proved by the fact that in December last a Departmental Committee was appointed to inquire into the law relating to coroners and coroners' inquests, and into the practice of coroners' courts. The members appointed to that Committee were Sir Mackenzie Dalzell Chalmers, K.C.B., C.S.I. (chairman), Sir Malcolm Morris, K.C.V.O., F.R.C.S.Edin., Sir Horatio Shephard, LL.D., Mr. T. A. (now Sir Thomas) Bramsdon, M.P., and Dr. William H. Wilcox. The committee has just issued a first report, in which it is stated that it has held seventeen meetings, at which thirty-two witnesses were examined, not only with regard to the matters specified in the terms of reference, but also in regard to deaths resulting from the administration of anaesthetics, and the danger arising from the use of flannelette in articles of clothing, as to which they were requested to make special inquiry in a letter addressed to the chairman by the Home Secretary on

December 24th, 1908. The inquiry is not yet complete, but a Blue Book of evidence has been issued. We propose to publish a summary of such parts of that evidence as directly concern the medical profession, but in the meantime it may be useful to give a general idea of its nature and scope.

Mr. James Brooke-Little, author of the article "Coroners" in Lord Halsbury's *Encyclopaedia*, gave a history of the office of coroner, which goes back to the twelfth century. In the Middle Ages the powers of coroners were more extensive than they are now. Their chief function was to hold inquests on the bodies of those who were supposed to have died either by violence or accident, and on the bodies of those who died in prison, and also in cases of serious bodily injury, rape and prison breach, breaking of houses, and practically nearly every felony. These functions have dropped off bit by bit. Apart from inability or misbehaviour, a county coroner holds his office for life. The grounds which, according to Mr. Brooke-Little, have been held sufficient to remove a coroner under the common jurisdiction of the Lord Chancellor are the following: If he have no sufficient knowledge or capacity; if he be so engaged in other business that he has not sufficient time to attend to his duties; if he be disabled and broken by age or disease. There are other reasons which do not concern us here. According to Mr. Brooke-Little there is no definition of "misbehaviour"; the Lord Chancellor has a great discretion in the matter. A borough coroner holds his office under the Municipal Corporation Act during good behaviour, but he is removable by the Lord Chancellor, not by the borough council. A coroner has not an absolute right to hold an inquest in every case in which he chooses to do so. If notice of the death is accompanied or followed by information that it was probably due to such cause as apoplexy or other "visitation of God," so as to show that an inquest is not necessary, the coroner may reasonably exercise his discretion by not holding an inquest. But if a coroner receives from the police authorities information of a sudden death in order that an inquest may be held, and there is no medical certificate of death from any natural cause, or other ground on which he can reasonably form an opinion as to the actual cause of death, it is his duty to hold an inquest; and in such case he cannot properly exercise any discretion to the contrary unless, by inquiry or otherwise, he has obtained such credible information as may be sufficient to satisfy a reasonable mind that the death arose from illness or some other cause rendering an inquest unnecessary. If a coroner has information which, if true, makes it his duty to hold an inquest, he is bound to hold such inquest; his jurisdiction to inquire does not depend upon the actual result of the inquiry. He cannot order a *post-mortem* examination unless he is holding an inquest. Mr. Brooke-Little stated that, supposing a person dies suddenly under a surgical operation, the coroner cannot give the surgeon permission to make a *post-mortem* examination. The relative can do so, unless the coroner determines to hold an inquest. As soon as he determines to do this he can instruct the medical man who was attending the deceased, or any other properly qualified medical man, to make an autopsy. In the case of a sudden death under a surgical operation there is no legal objection to a *post-mortem* examination being made, if the relatives consent, without the coroner being communicated with; but the coroner may still hold an inquest. If a person dies under an operation in a public institution, the coroner is bound, under a special Act of Parliament, to hold an inquest. If the death occurs in a private house, the coroner ought not to hold an inquest if an autopsy is made by a properly qualified man; but if he thinks that a possible case of negligence might be made out against the medical man, he would be justified in holding an inquest. Mr. Brooke-Little expressed the opinion that death under a surgical operation does not come within the meaning of a violent death in the words of the Act. If it appears that the deceased was a person who was not attended by any legally qualified practitioner, the coroner may summon any legally qualified man who is at the time in actual practice in or near the place where the death happened, and such witness may be asked to give his evidence as to how in his opinion the deceased came by his death. The coroner may summon the doctor who attended the case, and if no doctor attended, he may summon any neighbouring practitioner to give his opinion, even although he is an expert and not a witness as to facts. If a coroner deems it right to hold an inquest, the question whether a *post-mortem* examination should be made rests entirely with him, except to this extent: That if an autopsy has not been made, but a medical witness has been called, then, if the majority of the jury are of opinion that the cause of death has not been satisfactorily explained by the evidence of the medical practitioner called in, or by the other witnesses, they may require the coroner in writing to summon as a witness some other legally qualified practitioner named by them, and to direct a *post-mortem* examination to be made by him.

In regard to medical witnesses, Mr. Brooke-Little said the question was now entirely governed by statute. The Coroners Act, Section 21, makes provision that if the coroner knows that the deceased was attended by a practitioner he can summon that medical practitioner to come as a witness. If the person was not so attended, the coroner may summon any other qualified medical practitioner who is in actual practice in or near the place of death to come and give evidence. In either case the wording is "may" summon. He may also, either in the summons or at any time between the summons and the end of the inquest, direct such medical witness to make a *post-mortem* examination. But if any one states on oath before the coroner that in his belief the death of the deceased was caused partly or entirely by improper treatment of the person going to make the *post-mortem* examination, that person is not allowed to make it, and some other person must do it. Asked whether, if a medical man attends a person during his last illness and the person dies and an inquest is held, the coroner has power not to call to give evidence the medical man who has seen the person but some other medical man who has not seen the person during life, the witness replied that it was difficult to say that he had not the power; but if he acted in that way knowingly it would be an improper use of his power, and the local authority might, he thought, refuse to reimburse the coroner the expenses of such witness. The coroner was not bound to summon any medical witness at all, but if he did, and the deceased was attended in his last illness or at his death by a medical man, it was his duty to summon the one who was in attendance.

Dr. F. J. Waldo stated that the more experience he had as coroner the more *post-mortem* examinations he

ordered. In the majority of cases outside hospitals he got the practitioner who had attended the deceased during life, or had been called in at the time of death, to make the examination; but if on the evidence put before him by his officer, or in other ways, he could not form a satisfactory opinion, he thought it essential to get an independent man. Then he got his own special pathologist, who did it for the small statutory fee. He placed the greatest value on the clinical evidence of the doctor who had seen the deceased during life, but he used his own discretion. He did not think it necessary to have a special pathologist for all *post-mortem* examinations. He thought it should be left entirely to the discretion of the coroner. He assumed that he had the power now, but he thought it should be made more definite in the Act.

Mr. Isaac Bradley, Coroner for Birmingham, said he thought it was obligatory to hold an inquest when a patient died under an anaesthetic in the course of an operation. He would not include the case of an actual surgical operation.

Mr. A. J. Pepper said that, speaking from a very large experience, where he had examined bodies in which the *post-mortem* examination was supposed to have been complete, it had been very incomplete. When a *post-mortem* examination was made by an ordinary general practitioner, there were often appearances that might lead him wrong. The condition about which a mistake was most likely to be made was as to the cause of death and the mode of dying. The appearances might lead him to suspect violence when the death had, in fact, been natural. He suggested that the coroner should be compelled to call in an expert from a list nominated by the Home Secretary where there was any doubt as to the cause of death, and even where there was the merest suspicion or rumour of foul play. Reports of these examinations should be sent by the coroner to the Home Office. He thought that a medical man—whether he had attended the case previously, or had simply known the person, or had been called in at the time of death, or immediately afterwards—should always be called in. He thought the medical attendant's evidence essential, and it was perfectly monstrous to take his evidence and not call him.

Mr. Henslowe Wellington, Deputy Coroner for Westminster and the South-West District of London, said he did not suggest that deaths on the operating table in hospitals were not reported to the coroner. There were five large hospitals in his jurisdiction, and he had no reason to find fault with any of them upon the question of death under an anaesthetic or concealment of death.

Dr. G. Bateman, Deputy Coroner for the St. Albans District, Hertfordshire, said the coroner should always call in the medical practitioner who had attended the deceased, because the cause of death might be decided from clinical and also from pathological symptoms, and it might be necessary to combine them both in order to ascertain the true cause of death. The practitioner might be able to throw light upon the cause of death, from his personal knowledge, without a pathologist coming in after the event. Section 21 of the Coroners Act was decided in this sense years ago. It was the practice of most coroners to call in the doctor who had been in attendance, but there was one coroner who did not do this, and this had been the cause of a good deal of trouble. One inconvenience was that the cause of death could not properly be ascertained. It was unfair to the doctor that an inquiry should be held in his absence. He should be asked to be present and should be given an opportunity of watching the case. In a certain number of cases there would be no *post-mortem* signs of the disease from which the patient died; in such cases a pathologist who knew nothing of the symptoms during life would be absolutely unable to ascertain the cause of death. Wherever possible, both clinical and pathological evidence should be given.

Evidence as to many other points of practice in coroners' courts was given by various coroners. One was conspicuous by his absence. It is to be hoped that Mr. Troutbeck will be given an opportunity of explaining his reading of the law at a later sitting. The practice in Scotland was described by Professor Harvey Littlejohn, of Edinburgh.

Evidence as to anaesthetics, the dangers of particular agents, and the instruction of students in their administration, was given by Dr. Frederic Hewitt, Dr. Dudley Buxton, Sir Lauder Brunton, Mr. C. S. Tomes, Mr. Morton Smale, and others; and as to the certification of death, with special reference to cremation, by Mr. Herbert T. Herring. Dr. Hadwen gave evidence as to the risk of premature burial. Much other evidence was given by coroners, representatives of the police, and others, as to giving information of deaths, as to payment of witnesses and doctors, and many other points which cannot be dealt with now. We understand that it will be some time before the Committee issues its final report. Till then, of course, we refrain from making any comment on the evidence.

THE ANNUAL MEETING.

The Lord Lieutenant of Ireland and the Association.

Sir William Whitla, President of the British Medical Association, has received the following letter from His Excellency the Lord Lieutenant of Ireland:

Vice Regal Lodge,
Dublin,
August 2nd, 1909.

Dear Sir William Whitla,

Now that the memorable week of the British Medical Association's visit has been completed, I cannot help wishing to congratulate you both personally and officially regarding the conspicuous success which has characterized the proceedings collectively, and also with reference to the separate parts and events of the occasion.

There seems to be a general impression, which I am sure is well founded, that, combined with the many instructive and important deliverances and discussions, there has been awakened a large amount of intelligent interest on the part of the public with reference to the various questions and topics of far-reaching importance which have been dealt with and expounded during the Congress, and this I apprehend is eminently a result desired and aimed at by the Association.

Allow me now to express, on behalf of Lady Aberdeen and myself, most sincere thanks for the manner in which we were received by yourself as President and by all the officials of the Association, whose courtesy and thoughtfulness added so much to the pleasure of our attendance at the various meetings and reunions. And I cannot refrain from alluding once more to the honorary membership conferred on Lady Aberdeen, a distinction which will be a lasting source of gratification and encouragement.

Again thanking Lady Whitla and yourself, and with best wishes for the success of your Presidential term,

I remain,
Yours very faithfully,
Aberdeen.

Sir Wm. Whitla, M.D., LL.D.

Sir William Whitla has also received the following letter from Her Excellency the Countess of Aberdeen:

Vice Regal Lodge,
Dublin,
August 2nd, 1909.

Dear Sir William,

Will you allow me to add to His Excellency's letter a few words of grateful personal thanks for the kindness shown to me and to the Women's National Health Association by you and by the British Medical Association?

The honour you did me was altogether so unexpected and so surprising, and the stamp of approval set on the work of the Women's National Health Association so gratifying and encouraging, that I am still somewhat overwhelmed by my experiences. But I am sure it will give a great impetus to our health work generally.

May I ask you to convey to Lady Whitla our renewed thanks for your kind hospitality and for all the pleasure of the garden party in your beautiful grounds, and also for the two splendid bouquets she was good enough to present to me. We hope that you will accept the photographs which we are sending you and Lady Whitla as a remembrance of our visit to the British Medical Association under your Presidency, and we hope you will send us your photographs in return.

Yours sincerely,
Ishbel Aberdeen.

We are informed that Sir John Byers has received an extremely kind personal letter from Their Excellencies the Lord Lieutenant of Ireland and the Countess of Aberdeen, thanking very warmly Lady Byers and himself for their "most interesting and thoughtfully carried out entertainment," on Friday, July 30th, at Dreenagh House, Belfast, where a large number of the members of the British Medical Association met them at luncheon.

A Souvenir of the Meeting.

We understand that Sir William Whitla, President of the British Medical Association, has expressed his intention to present a copy of his work, in two volumes, entitled *The Practice and Theory of Medicine*, to every member of the Association who was present at the annual meeting recently held at Belfast. We are sure that the liberality of the President will be warmly appreciated, both on account of the value of the gift and the occasion of its bestowal. It will form a most interesting souvenir of a meeting which largely owed its success to the tact, courtesy, and genial hospitality of Sir William Whitla.

GENERAL NOTES ON THE MEETING.

By the time these notes appear, the majority of members who attended the Belfast meeting will be back in ordinary harness. Others more fortunate will be taking advantage of the facilities granted to holders of members' tickets by the London and North-Western and other railway companies for an extended tour, and will thus be seeing something of the beauties of southern and western Ireland. But for all alike the Belfast meeting and its strenuous doings will have become merely a memory. What is likely to be the primary outstanding impression? Probably a sense of the smoothness with which all arrangements worked, a dim realization of the skill and labour which secured it, and gratitude for the good-humoured courtesy of all classes.

These, it is true, are features of most annual meetings, but custom does not stale the pleasure which they cause, nor for those who know something of the engineering of meetings does it blunt the feeling of admiration—of half surprise—at the success witnessed.

The management of huge congresses, such as those which the annual meetings of the British Medical Association have now become, is a task which might well be deemed formidable even by professional organizers, and for men who have other affairs to attend to—their practices, whether consultant, specialist, or general, to carry on simultaneously—it means a vast amount of anxious thought and conscientious labour for months before the date of the meeting and a sleepless week during its actual progress.

This fact is worth putting forward, for few members probably realize to the full how much they owe to the honorary officials on such occasions as the meeting at Belfast. To whom their thanks this time are more particularly due it would be difficult to say, for each and all of the nine subcommittees appointed by the General Executive Committee performed their respective tasks equally well. No one, however, will readily forget the courtesy and thoughtfulness of the General Honorary Secretary of the Executive Committee, Dr. Cecil Shaw, and of his colleagues Dr. H. L. McKisack, and Mr. Howard Stevenson.

The Hotel, Lodgings, and General Purposes Committee, headed by Dr. William Calwell, with Drs. J. B. Moore and Gardner Robb as honorary secretaries, had a difficult task, for Belfast is not specially well off for hotels. Nevertheless, we heard of few people who did not find themselves comfortably housed, for the committee had managed to get ready any number of rooms in private houses, and to exclude from its lists all specimens of the proverbial lodging-house keeper, who is probably to be found in Belfast not less frequently than elsewhere.

In their choice of members of other subcommittees Sir William Whitla, Dr. Alexander Dempsey, President of the Ulster Branch, and Dr. W. G. Mackenzie, Chairman of the Belfast Division—the three leading members of the Executive Committee—were equally happy, for as those who went to Belfast well know, not only were the arrangements for the meetings of Sections thoroughly satisfactory, but each and every day was made thoroughly enjoyable. The day entertainments were managed by Mr. P. S. Kirk, the secretaries of the subcommittee being Drs. Charles Kevin and J. E. MacIlwaine; the evening entertainments by Dr. J. R. Davidson, with Mr. J. A. Craig and Dr. W. W. Mackenzie as secretaries; and the excursions by Dr. J. C. Martin, of Portrush, with Dr. J. J. Austin and Mr. R. J. Johnstone as secretaries. The only person who did not carry out his task to the thorough approbation of every one was a gentleman whose name was thoughtfully not disclosed, namely, the Clerk of the Weather. He is not, however, a member of the Association, and so, perhaps, not under the control of the Executive, which seemed to be able to command the very best services of every one else anywhere within fifty miles of Belfast. Nevertheless, it may be said for him that his behaviour was probably less due to carelessness or ill-will than to inability to make up his mind as to whether it was summer or winter, and in any case he supplied some excellent hours of sunshine and an interesting number of Hibernian samples of meteorological possibilities.

Of the generous scale and great success of the garden party given by Sir William and Lady Whitla at Lennoxvale mention was made last week. It was followed by an entertainment of similar character at Cabin Hill on the last day of the meeting. The guests, to the number of over 1,500, passed up the long winding avenue of this beautiful estate in a

continuous stream, to be welcomed by their host and hostess, Mr. and Mrs. R. J. McMordie, in an oak-panelled hall, converted for the nonce into a bower of pink and blue hydrangeas. The grounds, with their winding walks and beautifully-kept lawns, supplied a feast in themselves for beauty lovers; but for the more carnally-minded there were performances by society artistes, as well as crystal-gazers, palmists, and refreshments galore.

Somewhat allied in its general character was the entertainment offered by the Royal North of Ireland Yacht Club at Cultra. It was a kind of garden party, with a yacht race by way of centre of attraction. Some of the visitors travelled down by a special train others in automobiles and outside cars, and by half-past 3 in the afternoon the club grounds presented a very animated scene. The weather, a little showery at first, later on turned out attractively warm, and watching the progress of the race was a pleasant occupation. The Association proved itself to possess a much larger number of sailors than might have been expected, and the three-reach race was well contested. The boats used belonged to the No. 2 class, and were kindly placed at the disposition of the visitors by the club, while two prizes—a cigarette case and a travelling clock, both engraved with the arms of the club—generously provided by Dr. Donnan and Dr. Greenfield, were awarded. The captains of the winning boats proved to be Dr. J. T. Wigham and Dr. W. H. Brailey respectively, but the racing was very close, for less than ten minutes divided the first arrival at the winning post and the sixth and last. This party was, so far as we remember, an entire novelty in the way of entertainments at Annual Meetings, and was a great success, while, curiously enough, the cricket match in view fell through, in spite of the trouble which Dr. J. W. Taylor had taken in making all preliminary arrangements. It was impossible, however, to give effect to the idea, for members still energetic enough to wield the willow and ready to face a fast bowler were not forthcoming in adequate numbers. On the other hand, Dr. John Rusk found plenty of members desirous of refreshing their memories of a much more ancient game—namely, bowls. To enable them to do so, the Belfast Bowling Club hospitably threw open its grounds near Queen's College, and some amusing competitions were held.

Another entertainment which attracted an enormous crowd was that given on Thursday evening by Sir Robert Anderson and the Lady Mayoress at the City Hall. Probably every one had admired the exterior of this very striking piece of municipal architecture; as, however, the building is not intended for show purposes but for the transaction of the daily work of the authorities of the great city, few, perhaps, were prepared to see so beautifully proportioned and decorated an interior. Apart from the great Council Chamber it has a lofty reception room with a daïs at one end, a music balcony at the other, leading out of which are wide corridors, all communicating with a colonnaded gallery overlooking the marble entrance hall with its finely designed central fountain. From this hall mounts a broad marble staircase, and at the head of it the Lord Mayor and Lady Mayoress welcomed each guest in turn. The place is so big that, in spite of their number, there was never more than just sufficient crowding to make searching for friends an amusing task. An excellent band was playing, some solo singers performed at intervals, and refreshment tables were at the disposition of everybody from beginning to end of the evening, which on the departure in state of the Lord Lieutenant and the Countess of Aberdeen and their suite, terminated in a most enjoyable dance.

As was expected, the *al fresco* fête provided by the President and members of the Ulster Branch of the British Medical Association proved the *clou* of the meeting in the way of entertainments. It took place in the Botanic Gardens, and by way of playing "heads I win, tails you lose," with the meteorological official already mentioned, the Committee had caused to be erected a city of marquees, which rendered those present quite independent of the vagaries of the weather. Whether as a sequence or a consequence, not a drop of rain fell until quite late in the evening, so that meantime guests were able to wander about the gardens by the light of the thousands of fairy lights or listen to the various bands of musical entertainers at will. It need scarcely be said that the possible needs of the inner man were fully anticipated. Four or five marquees opening one into the other provided plenty of space for long tables of refreshments and for moving about and exchanging experiences, the series ending in a tent where the male portion of the assembly had an opportunity of comparing the liquid products of a certain well-known province in the more northerly part of France with those of Ireland in general. The evening, indeed, was all too short, and it is to be feared that not every one found time to visit the ferneries, which were most artistically lighted for the occasion. A very large house is devoted to them, and even by Kew the collection of tropical foliage of the smaller kind is not surpassed. At this entertainment, as at the other garden parties, their Excellencies the Lord Lieutenant and the Countess of Aberdeen were present, and members had an opportunity of making acquaintance with all that constitutes society in and around Belfast. Of the millinery no description can unfortunately be given; suffice it to say that it was not less good to look on than its wearers. Belfast, in short, did not fail either at this or any other entertainment to do Ireland justice, both in looks and conversation.

The needs of those whom amusement pure and simple does not satisfy, even in times of relaxation, were not overlooked by the Executive Committee, which, enlisting the sympathies of the great manufacturers of Belfast, arranged for the mysteries of several important industries to be explained to members. These included the intricate art of flax spinning at the works of the York Street Flax Spinning Company, and rope making at the Belfast Rope Works—both of them trades which involve dealing with many difficult problems of ventilation. In this connexion, perhaps, the most interesting visit of all was that paid to the Damask Works at Edenderry, for its owners, Messrs. J. Shaw, Brown, and Co. have created for their employees a model village somewhat on the lines of those at Bournville and Port Sunlight. The commercial results of such enterprises appear to be satisfactory, and the underlying idea is one which, if generally and thoroughly adopted, will go far towards nullifying the disadvantages of the inevitable predominance of urban over rural occupations. If Ireland develops on these lines all will yet be well with it.

Another interesting visit was that paid to Messrs. Gallaher's, tobacco manufacturers. The firm is one of the few which have stood out against the Tobacco combine, and its operations are conducted on such a large scale that visitors were able to gain a good idea of the whole of the processes involved in the conversion

of tobacco leaf into cigarettes and pipe fuel. At Messrs. Dunville's, whisky distilling was not actually proceeding, but the visitors had an opportunity of picking up some knowledge of the methods which have served to make this firm's whisky famous, and to the number of some 200 were entertained at a champagne luncheon. Irish whisky, it is clear, fears nor foe nor rival, even though cased in portly magnum capped with shining tinfoil.

Naturally also visitors were afforded an opportunity of realizing something of the importance of the part played by Belfast in the shipping world. Their experiences in this direction began on Tuesday, which was by no means too early, because it would be quite possible to live a good many weeks in Belfast without recognizing that it has vast docks within its area, and that it vies with Newcastle and Gateshead as a centre of the shipbuilding industry. On Tuesday upwards of a hundred members were received by Mr. Robert Thompson, Chairman of the Dock Commission, and some of his colleagues at the Bangor boat jetty. There the Commissioners' private steamer was in waiting, and after a short general cruise of inspection the visitors were taken to see the new Graving Dock and the Musgrave Channel, tea being served meanwhile. The following day Messrs. Workman and Clark's establishment was thrown open, and the visit proved exceedingly interesting to the many for whom marine engines, their interiors and component parts, are ever fascinating objects. Twenty-four hours then passed, and the remaining thirst for information regarding matters maritime was satisfied by a visit to the head quarters of a shipbuilding firm whose operations are of such magnitude as frequently to have evoked absolute poetry from engineering writers. The works occupy Queen's Island, where the guests were led by the Right Hon. A. M. Carlisle, in company with three or four other directors of Messrs. Harland and Wolff, Limited. Several gigantic liners in process of construction were seen, and the boiler shops, engine-fitting shops, and ship's carpenters' and various other departments inspected. The visit occupied almost two hours, and no one can fail to have been impressed by what was seen.

Quite of a different character was the visit of inspection which a good many members paid on the invitation of the Corporation of Belfast to examine the methods employed in dealing with the sewage of the city. Members already knew something of these, thanks to an elaborate paper on the subject read by Councillor Dr. Henry O'Neill in the Section devoted to Hygiene and Public Health, but they were grateful for the explanation supplied by Councillor M'Cullagh as to the special difficulties with which the sewage authorities in Belfast have to contend. These are partly due to the sluggishness of the river, which on receding leaves a large area of bare foreshore, but more especially to the omnipresence of the marine plant known as *Ulva latissima*. It thrives on the nitrates and free ammonia inevitably present in water in the neighbourhood of sewage outfalls, and, when it has reached a certain size, breaks away from its roots and scatters far and wide to decay in the sunshine. As the outcome of the findings of a Royal Commission, which made a prolonged inquiry into the matter a few years ago, the Corporation is at present centring its efforts on depriving the plant of nutriment by subjecting the sewage to an elaborate system of sedimentation, while it is also experimenting with various fashions of dealing with the problem which have been suggested. The visit ended with tea at an hotel during which a vote of thanks to the Corporation and to Councillor M'Cullagh was passed on the suggestion of Dr. Louis Parkes.

How the visits paid to the two sanatoriums, of which Belfast is already able to boast, to the famous Royal Victoria Hospital, and to the older but almost equally well-known Mater Infirmorum Hospital, should be classed is not quite certain. Many perhaps regarded them as elaborate tea parties, as a pleasant opportunity of meeting friends, and were well justified in doing so, for at each and all of them the authorities had prepared for their guests taking this view. They were equally prepared, however, to meet the desires of those who wished to examine carefully the provision made for the treatment of the sick at these various institutions. The parties at the White Abbey Sanatorium where the guests were received by Dr. and Mrs. Hall, Dr. Morgan and the Lady Superintendent (Miss E. Woods), and that to the Forster Green Sanatorium, took place on different days. This was a happy arrangement, since it enabled those specially interested in sanatorium work to compare institutions for the benefit of tuberculosis as conducted respectively by municipal authorities and through private benevolence. At the Forster Green Sanatorium it was a pleasure to all to meet the widow of the founder, a lady who, before the end of the afternoon, appropriately acknowledged a speech of thanks to the Committee for their hospitality, made on behalf of himself and his fellow guests by Professor Cameron. The gathering at the Mater Infirmorum Hospital was a very large one, and though tea and talk satisfied the requirements perhaps of the majority, the Reception Committee formed by the members of the medical and surgical staff had its hands kept full by those wishful to explore the spick and span wards. Even larger was the number of visitors who responded to the invitation of Mr. James Davidson, the Chairman of the Board of Management of the Royal Victoria Hospital. The added size was partly perhaps due to the fact that by the time the entertainment took place the meeting was more thoroughly under way than on Tuesday, when the reception at the Mater Infirmorum Hospital was held, partly because of curiosity excited by the special system of ventilation on which the Royal Victoria depends. This is the Plenum system, which has rarely hitherto been applied to any such great hospital as the Royal Victoria. The general arrangements of the institution and the fashion in which the Plenum system is utilized will be found fully described and illustrated by ground and other plans at page 25 of the second volume of the British Medical Journal for 1903 (see also vol. ii, 1904, page 697). Those who advocated the adoption of this system in the circumstances may be regarded as having been somewhat bold spirits, but their action seems fully justified by the results obtained. By way of testing these in a perfectly unbiassed fashion, we addressed inquiries casually to a large number of different persons who had attended the entertainment, and were much interested to find that while several of them were quite unaware that there was anything unusual in the system on which the hospital is constructed, all were ready to testify to the sweetness of the wards and their freedom from any trace of stuffiness.

An account was given last week of various sermons preached on the Sunday immediately preceding the commencement of the scientific portion of the proceedings of the Annual Meeting, but those notes would not be complete without some reference at least to an address delivered at St. George's Parish Church by the Rev. H. D. Murphy, D.D. It is true that it was

not intended for the consumption of medical men, but, nevertheless, dealt with a matter which is necessarily of high interest to practically every member of the medical profession—namely, the question of pounds, shillings, and pence, and the moral duty of seeing that the services of medical men are not merely remunerated by more or less empty expressions of gratitude. The Rev. Dr. H. D. Murphy, in short, dealt faithfully and plainly with the sins of the individual whose existence has given rise to a heading which of late has frequently figured in these columns—"vicarious philanthropist"—and preached on that subject as apt and eloquent a sermon as even the least frequently paid medical man could desire. He took as his text a passage from the Apocrypha with which perhaps few people are acquainted. It is not canonical, but is nevertheless a part of the Holy Scriptures which "the Church doth read for example of "life and instruction of manners." It runs, "Honour "a physician with the honour due unto him, for of the "Most High cometh healing, and he shall receive "honour of the King. The skill of the physician shall "lift up his head, and in the sight of great men he "shall be in admiration. There is a time when in "their hands there is great success." The reverend advocate of the cause of medical men preluded his address by stating that no one had suggested to him the subject of his sermon, no one was responsible for what he was about to say except himself, in whose mind the thought had long dwelt of addressing his congregation on the subject of the shameful way in which medical men are treated by some of those who owe to them their lives.

THE week ended as usual in a series of Saturday excursions, all of which were well selected and well arranged. During nearly the whole of the preceding night rain fell heavily, and the prospects of large parties seemed doubtful, more especially as an early start from home was essential. In the event, however, everything turned out in the happiest fashion. Remembering, doubtless, the old proverb, "Rain before seven, fine by eleven," some three hundred visitors bodly faced the drizzle and were rewarded almost as soon as they had taken seats in the trains by a burst of sunshine. The day, in short, turned out to be as attractive in point of weather as in everything else. One little fact proves the success of the efforts of the excursions subcommittee; on questioning members of the returning parties each was found to be preening itself on its choice. Each party, in short, was convinced that its own expedition must have been much the pleasantest. A further good point in the arrangements was that taking advantage of the excursion plans did not, as is sometimes the case, necessarily interfere with homeward flights, returns to Belfast being all timed so as to permit of visitors catching if they would the various cross-channel steamers. On its Saturday's work, therefore, the Executive is to be as warmly congratulated as on all the rest, since perhaps for no other part of an Annual Meeting is it more difficult to secure success than for the terminal excursions. Play the piper ever so gaily, guests do not always dance—not because they would not but because they may not, owing to the necessity of hastening home to resume once more the trivial round, the common and ill-paid task.

TWO of the parties started together by special train before 9 o'clock in the morning, travelling northwards. The larger division went on to Portrush, where, after a light luncheon had been served, all climbed into the waiting electric cars and started for the Giant's Causeway. The tram line or light electric railway follows the edge of the cliff, and from time to time brief pauses were made for a peep down into the clear water or a more prolonged view of some particularly attractive promontory. Midway Dunluce Castle was reached and this picturesque ruined stronghold thoroughly explored. Another quarter of an hour on the cars and the Causeway was reached. Some opted for exploration of the caves by boat, landing in one of the more distant bays which break the line of basalt columns; but the majority followed the shore route on foot, and were well rewarded, for walking proved easy, and they were able to examine the remarkable formation of the foreshore in more leisurely fashion. It was made clear that science and some superstition are not entirely incompatibles, for few failed to take a seat on the wishing-stone. Perhaps they were merely resting, but why that particular spot, when the whole shore is strewn with natural armchairs, and looks in parts not unlike the auditorum of a Roman theatre? A few endeavoured to get as far as Port-na-Spania Cove, where an Armada vessel came ashore. It is believed to have intended to attack Dunluce Castle and mistook certain curious natural pinnacles on the cliff for its turrets. The pleasure of this visit was greatly enhanced by the presence of Mr. Traill, a brother of the well-known Provost of Trinity College, Dublin. He has a house in the neighbourhood, has made a prolonged study of its characteristics, and in a few short sentences at intervals managed to convey quite a clear notion of its geological and other history. The party got back to Portrush by 4 o'clock and found a well-spread table awaiting it. On conclusion of the meal and after a brief stroll through the town, the majority of the party then entrained for Belfast. The impression left was that either at Portrush or the Causeway an excellent summer holiday could be spent. The sands are magnificent, the cliffs positively beg for exploration, and the golf links are hard to beat.

THE smaller party, which quitted the main line at Ballymena, travelled on to Parkmore by a narrow gauge tram, having a view meanwhile of the Flemish mountain, on which, according to tradition, St. Patrick passed his boyhood as a slave and herder of cattle. From Parkmore, lying 1,000 ft. above sea level, and the highest railway station in Ireland, brakes took the party to the head of the picturesque Glenariff Glen. It is a rocky gorge some two miles long, excavated by the torrent coursing through it. Of its kind, this gorge with its numerous cascades and overhanging foliage, is perfect in its scenery, and as the path is downhill all the way, exploring it on foot, as did the party, entails no undue exertion. On reaching the foot the brakes were again requisitioned and took the party to luncheon at the hotel, into which the Garron Tower—a former seat of the Londonderry family on a lofty terrace formed by a gigantic landslip—has now been converted. Starting afresh in the afternoon the party then drove along the coast road through Carnlough and close to Glenarm Castle—the chief residence of the Earl of Antrim—arriving at length, tired but happy, at Larne about 6 p.m. Some of the party returned forthwith to Belfast, buoyed up by a wealth of memory-pictures of the beautiful scenery viewed during the day, while others, after a refreshing leisurely tea, explored the well-known starting point for Scotland, returning to Belfast late in the evening.

THE third party left home somewhat later, and, being bound for Carlingford Lough and the Kingdom of Mourne, travelled in a south-easterly direction. They passed on the way Lisburn, the birthplace of the

linen industry of Ireland, and, reaching Warrenpoint, were met by Mr. Joseph Carroll, the Chairman of the Urban Council, Mr. W. Johnson, its solicitor, and were later joined by Drs. W. W. Glenny and Vesey and several other residents, who kindly took upon themselves the duties of ciceronage. Warrenpoint itself, with its beautiful surroundings and the blue summits of the Mourne Mountains in the distance, is very attractive, but two separate expeditions were promptly started. Steamer excursions are often not popular, but the arm of the sea at the head of which Warrenpoint stands is landlocked—a cross in appearance and formation, as some one suggested, between a fjord in Norway and a tarn in the Highlands—and was so smooth that most people jumped at the chance of a cruise round its shores. They thus saw the sundry castles for which this lough is famous. It was the site of much fighting, and the castles, one of which dates from the first decade of the eleventh century, are all relics of the first British invasion of Ireland. The rest of the party went by land to Rostrevor, nestling at the base of a tree-clad promontory on the other side of the lough; some even essayed a climb of the nearest peaks of the Mourne Mountains, the fastnesses whence the native Irish for years continued to swoop down to ravish with fire and sword the fertile lands wrested from them by the Sassenach invaders. About 2 o'clock all reassembled at Warrenpoint, and enjoyed luncheon to the strains of an excellent band. The chair was taken by Mr. J. Carroll, who in due course expressed the pleasure felt by the Amusements Committee of the town in being able to take some share in making the visit of the British Medical Association pleasantly memorable to its members. His remarks and the hospitality shown met with due acknowledgement from Dr. Rayner, the Treasurer of the Association, who formed one of the party, and the company, after a toast to the Chairman, adjourned to inspect the sea baths. Some Pierrot performances and band music followed, and finally, after a tea-party in the Municipal Gardens, the hour arrived for taking the train homewards.

Finally remain to be mentioned the golf doings of the week. They made it clear that the medical golfer, at any rate, practises what he preaches, and is disposed at times to put aside even scientific discussion in favour of quiet outdoor exercise. The excuse, however, was ample, for there are as many as six most attractive links in the immediate vicinity of Belfast, and all of them were hospitably placed at the disposition of members. The chief event of the week, however, in this connexion was the first competition for the Belfast Golf Cup generously offered by the Ulster Medical Society on the suggestion of its President, Mr. T. S. Kirk. The competition took place, not on any of the Belfast links, but on those of the County Down Golf Club, near Newcastle, at the foot of Sleive Donard, the highest peak of the Mourne Mountains. The hosts of the day were Mr. and Mrs. Kirk, who welcomed at the club house the 200 or more guests, who arrived by special train and otherwise in the course of Thursday morning, and were assisted by Dr. and Mrs. R. L. Bell of Newcastle, both at luncheon and tea. The course is over 6,000 yards long, and, thanks to its abounding natural and artificial hazards, put the skill of competitors thoroughly to the test. The eventual winner proved to be Dr. Shackleton, of Holywood, his score being 2 up on bogey—80—with a handicap of 14. The second winner was Dr. George Cheyne, of Edinburgh, and both, about 5 p.m., received their prizes from the hands of Mrs. Kirk. The day was one of thorough success both from the view of serious golfers and from that of mere amateurs or onlookers, for the course was at its best—which is very hard to beat—the day fine, the rugged beauties of the course a pleasure to note in themselves, and 'tween times there were putting and approaching competitions for the benefit of the numerous ladies who graced the function by their presence.

National Temperance League.

Another occurrence during the week of the meeting is one which, formally speaking, was not part of its official events; nevertheless, reference to it may well be made in this place, since it is of annual recurrence and is looked forward to by a large proportion of members. This is the annual breakfast provided by the National Temperance League, which on this occasion shared the duty and responsibilities of the position of host with the Irish Temperance League. It was the Chairman of the latter body, the Right Hon Sir Robert Anderson, Lord Mayor of Belfast, who presided at the breakfast this year, and he was supported by Sir James Henderson, Chairman of the Technical Institute, whose committee had placed their magnificent rooms at the disposition of the conjoint leagues; by Dr. Crothers, of Hartford, Connecticut, U.S.A., and many others; while apologies for unavoidable absence were received from the President of the Association (Sir William Whitla) and Sir Victor Horsley. The principal business of this breakfast conference was to hear from Dr. T. N. Kelynack a summary of the scientific evidence with regard to the effects of alcohol presented at the recent International Congress in London, of which some account has already appeared in these columns. His address was a "scientifically dispassionate" summary of the facts on which the modern medical advocate of total abstinence relies, and he started with the postulate that, "although science claims the right to guide "and govern in such essentially a medico-sociological "problem as that presented by alcoholism, it must be "remembered that at present we stand only at the "beginning of our researches." Quoting the results of Professor Laitinen's laborious researches on the influence of alcohol in decreasing resistance to disease, the speaker enforced, by various observations, the necessity for a clear understanding of all the causal factors in alcoholism and of its relation to individual and racial deterioration. Laitinen's view that alcohol, even in small quantities, has an injurious effect on human offspring was, he claimed, endorsed and illustrated by the evidence of Drs. F. W. Mott and Clouston, Aschaffenburg, Holitscher, and Branthwaite. A vote of thanks to Dr. Kelynack for his address was moved by Dr. T. Crothers and seconded by Dr. Norman Barnett, the Honorary Secretary of the Belfast Branch of the British Medical Temperance Association. The latter was pleased to think that the breakfast that morning had been one of the most successful ever held under similar auspices. It was also a matter for congratulation that as time passed many medical men, formerly disposed to regard the question of temperance reform as a mere fad, were coming to take a deep and sympathetic interest in its progress. The motion was also supported by Mr. McAdam Eccles (of St. Bartholomew's Hospital), General Honorary Secretary of the British Medical Temperance Association. Belfast, he said, was clearly building morally and architecturally with a view to the future, more especially in regard to the education of the young, on which to a very great extent the future progress of the struggle against alcoholism depended. The British Medical Temperance Association, composed solely of medical men and medical women

pledged to total abstinence, now numbered about 700, of whom 89 were resident in Ireland. The success of the Belfast branch was largely due to the energetic work of its president, Dr. Calwell, and of its honorary secretary, Dr. Norman Barnett. The meeting also had the advantage of hearing a few words from Mr. J. T. Rae, the Secretary of the National Temperance League. He mentioned that the breakfasts had been started by his late father, and that they had been held annually for over forty years.

IRISH MEDICAL SCHOOLS' AND GRADUATES' ASSOCIATION.

ANOTHER similarly unofficial incident in the course of the week was the annual summer meeting and luncheon of the Irish Medical Schools' and Graduates' Association, held at the Medical Institute. There was a large attendance of members and guests, including ladies. Sir Charles Cameron (Dublin) was in the chair, and amongst those present were the Rev. Dr. T. Hamilton (Vice-Chancellor, Queen's University, Belfast), Dr. Sinclair White (retiring President of the British Medical Association), Dr. E. Rayner (its Honorary Treasurer), and Dr. Dawson Williams. Dr. J. A. Macdonald, Mr. H. J. Ballance, Mr. R. H. Kinsey, Mr. Guy Elliston, Drs. Smith Whitaker, A. Cox, Shepherd Boyd, Buist, Vernon Dodd, R. Fegan, J. H. Ewart, Rev. Dr. Seaver, Dr. J. J. Macan, Dr. J. Hobbs Crampton and Dr. W. Douglas, the last three being respectively Chairman of Council and Honorary Secretaries of this representative of medical educational centres in Ireland.

A MENTAL HOSPITAL FOR LONDON.

THE report of the Asylums Committee of the London County Council, which appeared in the JOURNAL of July 24th, p. 234, led us to cherish the hope that at last the Council was about to make a serious endeavour to carry into effect the scheme of a mental hospital which has for years past been advocated by this JOURNAL. For a considerable time it has seemed as if Dr. Maudsley's magnificent offer of £30,000 towards the foundation of such a hospital was to be allowed to lapse owing to an ill-judged economy, doubtless inspired by the near approach of a general municipal election. From the report referred to it appeared that a site for the hospital had been found. The Asylums Committee also proposed, in accordance with the recommendation of the Royal Commission on the Care and Control of the Feeble-minded, that two receiving houses should be established to which alleged lunatics should be taken instead of to the workhouse. There they could be kept under observation and treatment till it was ascertained whether they were fit to be discharged or the mental disease was of such a nature as to make it necessary to send them to an asylum. The Finance Committee, while approving of the proposals of the Asylums Committee, expressed the opinion that the Council should in the meantime content itself with obtaining parliamentary powers to establish one receiving house by way of experiment. It suggested that this receiving house should be "on the site of the proposed mental "hospital." The wording of this recommendation must have struck a careful reader as rather ambiguous, as it might be taken to mean that the receiving house was to be a substitute for the hospital. We were led to understand, however, that the receiving house would be a separate establishment, standing in its own grounds, adjoining those of the mental hospital. Such an arrangement would in some ways have had considerable advantages. Last week we announced that it had been decided to defer the consideration of the report of the Asylums Committee till after the summer recess. This, we fear, means that the matter is to be indefinitely hung up. This fear is confirmed by information which we have received that the negotiations for the purchase of the site chosen for the mental hospital, which were believed to be all but formally completed, have at the last moment been broken off. For this, as far as we know, the London County Council is not to blame, but it is none the less unfortunate, and we are afraid that the fact may be used as a pretext for further delay in giving effect to Dr. Maudsley's benevolent intention.

THE SIXTEENTH INTERNATIONAL CONGRESS OF MEDICINE.

A MEETING of the National Committee for Great Britain and Ireland was held at the rooms of the Medical Society of London on July 22nd, 1909, Dr. F. W. Pavy, F.R.S., President, in the chair. It was proposed by Sir William J. Sinclair and seconded by Mr. L. Eliot Creasy, that the members of the National Committee be circularized as to the advisability of asking His Majesty's Government to invite the Seventeenth International Congress of Medicine to meet in this country. A report was made upon the appointment of official delegates at the Budapest Congress. It was also pointed out that members of the Congress who desire to travel with the Royal Society of Medicine party shall communicate at once with Mr. J. V. W. Macalister, 20, Hanover Square, W. The meeting closed with a vote of thanks to the Medical Society of London for the use of the rooms.

LEEDS HEALTH CONGRESS.

THIS is the age of congresses, and though some of them might pass into the regions of perpetual silence without drawback to the progress of the world, there is plenty of excuse for those dealing more or less authoritatively with questions of public health. They bring together workers in different classes of public health administration and in their train a host of dabblers who leave none the worse for having been in contact with real experts. Furthermore, though the sectional discussions may not be of any great scientific value, they afford opportunities of putting nails in the coffins of the fads in which the world at present runs riot, and attract the attention of the general public to really sound conceptions of desirable public and private life conduct. But though there is ample room for one such congress a year, there is hardly space for two; on this ground alone, therefore, the decision of that old standing body, the Royal Sanitary Institute, to join hands with its younger brother, the Royal Institute of Public Health, and hold a joint congress at Leeds is to be regarded as excellent. The result was a very useful week's work which terminated just in time to allow some of those present to hurry over to Ireland for the meeting at Belfast. The work was divided among four or five Sections dealing respectively with Industrial Hygiene, Child Study, Preventive Medicine, and Engineering and Architectural Work, and at each of them papers of interest were read by well-known medical officers of health and other authorities. Leeds as a whole, moreover, and its university, in which, knowing that both institutions were in search of a meeting place, the idea of a joint congress would seem to have practically originated, offered every facility. The plan was taken up by Dr. Spottiswoode Cameron, the Medical Officer of Health for Leeds, and it is mainly to his powers of organization that the success of the congress was due.

BRITISH PHARMACEUTICAL CONFERENCE.

THE British Pharmaceutical Conference began work at Newcastle-on-Tyne last week under the presidency of

Mr. J. F. Tocher, B.Sc., F.I.C., a pharmacist of Peterhead, Aberdeenshire, a member of the Board of Examiners for Scotland, and known likewise in connexion with the study of physical anthropology. He devoted his presidential address to the consideration of present-day problems in the pharmaceutical world of a medico-political and scientific character, and before the end of the meeting introduced a discussion on a subject of common interest to pharmacists and medical men, "Should dispensing "of medical prescriptions be exclusively confined "to pharmacists?" In the course of his paper on this subject Mr. Tocher considered several methods by which a desired separation between the practice of medicine and the practice of pharmacy might possibly be brought about, but pointed out that it was only in cordial co-operation between bodies truly representative of medicine and of pharmacy respectively that hope of settlement of the various problems involved really lay. As a practical means to that end he was disposed to urge an attempt to bring about the institution of a joint standing committee formed partly of members of the British Medical Association and partly of members of the British Pharmaceutical Conference. His idea, however, was, he indicated, still in embryo, and the general discussion which followed his introductory remarks ended in a resolution that the matter should be referred to the Executive of the British Pharmaceutical Conference for consideration, power being given to it to take any steps necessary to arrange for an exchange of views between the British Medical Association and itself. Before the Conference separated an invitation to meet next year at Cambridge was received and accepted.

AN OPHTHALMOLOGICAL CONGRESS.

At a meeting held at Oxford on July 15th it was decided to place the annual meeting at Oxford on a permanent footing. Mr. Sydney Stephenson (London) moved, and Dr. R. A. Reeve (Toronto) seconded, the the following resolution: "That the time has now "come when it is advisable to place upon a permanent "footing the annual meeting at Oxford of those in-"terested in ophthalmology." The motion, which was supported by Professor Deutschmann (Hamburg), Professor Motais (Angers), Professor Marc Dufour (Lausanne), Dr. Wendell Reber (Philadelphia), Dr. Vail (Cincinnatti), Dr. L. Werner (Dublin), Mr. R. J. Coulter (Newport), and Dr. H. Walker (Glasgow), was carried without a dissentient voice. It was then moved by Professor Osler, seconded by Mr. F. M. Granger (Chester). supported by Professor Gotch, and carried *nemine contradicente*: "That the Oxford Ophthalmo-"logical Congress be, and hereby is, constituted." Lastly, on the motion of Dr. Hill Griffith (Manchester) and Mr. Rayner D. Batten (London), a provisional committee (with power to add to their number) was appointed to make the necessary arrangements and to report in due course. The committee consisted of Sir Anderson Critchett, Bart. (London), Sir Henry Swanzy (Dublin), Dr. George Mackay (Edinburgh), Professor Osler (Oxford), Dr. Hill Griffith (Manchester), Professor Greeff (Berlin), Professor Dufour (Lausanne), Professor Deutschmann (Hamburg), Dr. Darier (Paris), and Dr. Wendell Reber (Philadelphia), together with Mr. Robert W. Doyne as chairman, and Mr. Sydney Stephenson as secretary.

THE OPIUM QUESTION.

We learn from the *Medical Record* that the United States has invited all the countries which participated in the meeting of the International Opium Commission at Shanghai, China, last February to send delegates to a second conference, to be held at The Hague in the near future, at which means will be considered for the international control of the production, manufacture, and traffic in opium, with a view to the complete suppression of the use of opium, except for medicinal purposes. Dr. Hamilton Wright, who was one of the American delegates to the conference at Shanghai, is preparing a programme to govern the discussion of the conference. It is hoped that the conference will also take up the question of the use of cocaine and other narcotics and habit-forming drugs. Dr. Wright is preparing legislation for submission to the United States Congress, which, if enacted, will place the manufacture of and inter-State traffic in habit-forming drugs under the supervision of the Bureau of Internal Revenue.

We are requested to state that the library and rooms of the Royal Society of Medicine will be closed during the month of August for cleaning and alterations.

Sir Malcolm Morris, K.C.V.O., and Dr. Newsholme, Medical Officer to the Local Government Board, have been appointed delegates of His Majesty's Government to the International Congress on Leprosy, to be held at Bergen from August 16th to 19th.

Medical Notes in Parliament.

[From our Lobby Correspondent.]

The Examination of Imported Meat.—Mr. Watt asked the President of the Local Government Board whether, in regulations under the Public Health (Regulations as to Food) Act, it was the Customs officer whose duty it was to call in the medical officer of health to examine imported meat which the Customs officer considered unsound; if so, would he say whether that official was qualified by training to decide what meat was diseased and what meat was wholesome; and, if not, would he alter the regulation so that all meats imported were subjected to expert examination. Mr. Burns said that it was the case that an officer of Customs would not be qualified by training to decide what meat was diseased and what meat was wholesome, but the regulations did not require him to do this. His duties under them were to require that certain classes of foreign meat, whether it was diseased or not, should not be removed until they had been examined by the medical officer of health, and that other classes of foreign meat should not be removed if, by reason of facts brought to his knowledge, or of representations made to him, he was of opinion that the meat required examination by the medical officer of health. The responsibility for expert examination rested with the medical officer of health, and he might examine any foreign meat whilst it was still in the district, although it had not been detained by the officer of Customs. It did not appear to him that any alteration of the regulations was necessary.

Hammersmith Infirmary.—Mr. James Parker asked the President of the Local Government Board last week whether his attention had been called to the treatment towards Mr. Jameson by the Hammersmith Infirmary officials because he refused to undergo an operation on his leg and was turned out in consequence, although the infirmary doctor had to remove the splints from his leg to pass him out; and, seeing that this man was readmitted an hour afterwards and was subjected to bad treatment on readmission, would he cause an inquiry to be made about the matter? Mr. Burns replied that he had received complaint with regard to this case, and had made inquiry with respect to it. Jameson was admitted to the infirmary on January 5th. The splint was removed on the 6th, not apparently for the purpose of passing him out, but because it was no longer required and because the sinuses from which he suffered rendered its continuance undesirable. On the 8th he declined to undergo an operation on his leg. He was discharged on the 9th, not, as he understood, on this account, but at his own request. He was readmitted

the same day. The allegation that he then received bad treatment was entirely denied by the officers concerned, whom he had caused to be questioned on the subject, and he did not find any evidence in support of it.

Vaccination Order, 1907, Declarations.—Sir Maurice Levy asked the President of the Local Government Board whether he was aware that a number of parents had been misled by the wording of Form Q, issued under the Vaccination Order of 1907, into believing that they were at liberty to make a declaration under the Vaccination Act, 1907, within four months and seven days of the birth of a child provided the vaccination officer received the declaration within that period, whereas the declaration was void if made after four months had elapsed from the birth; and whether he could in some way alter the wording of the form to prevent any further misconception on this point. Mr. Burns replied that he had received some representations on this subject, and he would give consideration to them. He might, however, point out that in the Notice of the Requirement of Vaccination which was given by the Registrar of Births and Deaths to the parent or other person registering the birth of a child it was expressly stated that the statutory declaration must be made within four months from the birth of the child.

Croydon Rural District Water Supply and Drainage.—Last week Mr. James Parker called the attention of the President of the Local Government Board to the reports of the Medical Officer of Health for Croydon, which stated that a large number of cesspools existed in the rural district, and that great danger arose therefrom to the water supply, and asked what action the Board proposed to take in this case and other cases in which there was a water supply from chalks. Mr. Burns said that he was aware of the reports referred to. He had communicated with the rural district council, and had been informed that they had succeeded in persuading a considerable proportion of the owners to connect their premises with the public sewers. He had advised them as to the powers which they possessed for dealing with cases where such connexions had not been made, and he had subsequently issued an Order conferring upon them certain additional powers under the Public Health Acts Amendment Act, 1907. Further, he was causing some scientific investigations to be made with regard to chemical means of purifying chalk waters. He was fully alive to the importance of the subject.

Gordon College, Khartoum.—Sir H. Craik asked the Secretary for Foreign Affairs whether increased assistance could not be given to the Gordon College in consideration of the important bacteriological investigations conducted in the College with the object of preventing malaria and other diseases. Mr. George Greenwood followed this by asking whether the bacteriological experiments referred to were not in fact conducted in the Wellcome Research Laboratories, equipped by a member of the firm of Burroughs and Wellcome; whether his attention had been called to the *Journal of Pathology* of March, 1906, giving an illustrated account of a series of very cruel experiments on dogs and monkeys by inoculating them with sleeping sickness, without thereby advancing the cause of knowledge or science by one jot or tittle; and whether, in view of the great and growing body of opinion hostile to such experiments, he would refrain from devoting public moneys to their promotion. Sir Edward Grey said that he had no information on the points raised in the supplementary question. The question of assistance from the Egyptian Exchequer was a matter for the decision of the Egyptian Government, but he might point out that Sir Eldon Gorst stated in his annual report on Egypt that the expenditure on education had been increased, in the budgets of the last few years, to the utmost extent which the resources of the country would allow. In the Soudan in particular there were many objects absolutely necessary to the country, such as improvements of means of communication, which must be considered. With regard to assistance from the British Exchequer, although he was quite alive to the merits of the Gordon College, and much appreciated the value of its work, he feared there was no precedent for subsidizing such educational establishments from the British Exchequer. Though he could not hold out hopes of a grant of this nature, he could assure the hon. member that it was the desire of His Majesty's Government that the work of the Gordon College should receive every support and encouragement that could be given as opportunity arose, either from public funds or private benevolence.

Experiments on Mosquitos at Mian Mir.—Mr. Ramsay Macdonald asked the Under Secretary for India whether his attention had been called to a paper read by Captain James at the Bombay Medical Congress last October, in which it was stated that the attempts made at Mian Mir to extirpate malaria-bearing mosquitos had failed, and that malaria was on the increase, and to replies by Surgeon-General Hamilton, Colonel Barrow, and others; and whether, in view of the importance both to the white and native population of India of these experiments to extirpate malaria, the Government would see its way to undertake an impartial but authoritative inquiry into the Mian Mir experiment. The Under Secretary for India replied that the proceedings of the Medical Congress held in Bombay in February last had not reached the Secretary of State, but he had seen a notice in the Bombay newspapers of a paper read by Captain James, recounting the results of an investigation into the health of the population of the Mian Mir cantonment. The Government of India would be consulted on the suggestion made.

Milk and Dairies (Scotland) Bill.—On Thursday last week this bill was again before the House of Lords, and in Clause 2 the words "or maker of butter or cheese" were inserted. Amendments were made as regards the registration of dairies and the withdrawal of certificates of registration, and a new clause providing for the co-operation between local authorities in dealing with tuberculosis in cows. As regards the expenses of administering the Act, Lord Carrington said the matter was under careful consideration, and he promised to make a statement before the third reading.

The Local Education Authorities (Medical Treatment) Bill came on for second reading in the Lords on Thursday in last week, and, after a speech from Lord Donoughmore explaining the objects of the bill, Lord Crewe said the Government would offer no opposition to the bill, which had passed through the House of Commons. He hoped, however, that it would be sympathetically applied by the local authorities. It would be most unfortunate if the effect of the bill were to discourage parents who were poor but not absolutely indigent from having recourse to this medical treatment for their children. The bill was then read a second time.

Epidemic Disease in Native and European Army in India.—Last week a return was ordered, on the motion of Sir Wm. Collins, showing the cases of and deaths from enteric fever, cholera, plague, and small-pox (with corresponding rates per 1,000) in the native army and among European troops in India, respectively, for each year from 1900 to 1908, inclusive.

Poor Law Medical Officers (Scotland).—Mr. Cathcart Wason has succeeded in getting a return ordered showing in how many and what parishes during the past three years Poor Law medical officers in Scotland have vacated office, and what period in each case has elapsed before the appointments have been permanently refilled.

Death Registration in India.—On Monday the Master of Elibank, in reply to Mr. Vincent Kennedy, said that death registration was instituted generally in British India between 1870 and 1875. There was no reliable record of the number of deaths resulting from starvation or famine. In times of famine special efforts were made to secure an exact report of deaths directly resulting from starvation, but the number of deaths so recorded was small, and was not an indication of the excess mortality directly or indirectly brought about by privation in seasons of drought and scarcity.

England and Wales.

[From our Special Correspondents.]

LONDON.

Public Health Committee of the County Council.

At the meeting of the London County Council on July 27th the Public Health Committee recommended the Council to initiate legislation next session for the sanitary regulation of stables and the inspection of food exposed for sale on street barrows (British Medical Journal, July 17th, p. 888). The proposal met with considerable opposition.

Mr. P. C. Simmons moved the reference back. He explained that he did not object to the inspection of costermongers, and he understood that the costermongers themselves were not opposed to it, but he pointed to the increase of motor traffic, and suggested that there would soon be comparatively few stables in London, rendering the proposed legislation unnecessary.

Mr. Whitaker Thompson, who seconded, thought it would be difficult for the borough councils to inspect costermongers' barrows.

Mr. Gilbert Johnstone, in defending the proposals of his Committee, said they had in mind large stables of cartage contractors or cab proprietors. On the cleanliness of these the extent of the fly nuisance very largely depended. In his experience this nuisance was worse in the East End of London than in Egypt. Further, if stables were more cleanly it would be possible to stamp out glanders, in dealing with which the Council spent thousands of pounds annually. As regards costermongers, the law at present discriminated unfairly against shopkeepers, who were subject to inspection, while their competitors were not. There was nothing to prevent a costermonger using a filthy barrow or washing it with dirty water. The only power of the sanitary authorities was to seize food absolutely unsound. Nine of the borough councils wished to have these powers.

Dr. Beaton moved an amendment to refer the matter back as far as it applied to stables.

This was agreed to as a substantive motion, but on a division less than two-thirds of the members voted in favour, and therefore under standing orders the whole proposal fell through.

OXFORD.

The Prevention of Consumption.

A meeting was held on Monday, July 19th, at Professor Osler's house in Oxford, to consider what steps should be taken in the County of Oxfordshire for the prevention of consumption. Mr. W. H. Ashhurst presided, and among those present were Professor Osler, Sir Ernest Trevelyan, Mr. Vernon and Lady Mary Watney, Dr. A. L. Ormerod (Medical Officer of Health for the city), Dr. Collier, Dr. Drew, Dr. Coles, Dr. Banks, Dr. Esther Carling, and many others. Letters of sympathy and regret at non-attendance were received from the Bishop of Oxford, Lord Valentia, and the Rev. L. R. Phelps. Miss Price read a letter which it was proposed to send to the Oxfordshire County Council. The signatories asked the Council, with a view to an exact record of the extent and situation of the illness, to adopt the following measures:

(*a*) Notification: either (1) voluntary notification, which obtains at Brighton, or (2) compulsory notification, as at Sheffield. (*b*) Preventive measures, such as the dissemination of information as to the nature and danger of the disease by addresses given in towns and villages in the country by competent persons. (*c*) Curative measures, by the provision of sanatorium treatment for all suitable cases in the following categories: (i) For a month to train patients in personal hygiene and the general management of the illness, so as to minimize the risk of the spread of infection when they return to their homes and their work. (ii) For a longer period in cases where the disease is in so early a stage that a cure is possible or probable. (iii) For the dying. In the last stages of a consumptive's life the danger of infection to those about him is greatest, and stringent precautions and careful nursing become necessary. It was stated that several borough councils and unions in the neighbourhood had met the demand for sanatorium treatment by sending their patients to the Maitland Sanatorium at Peppard, where they permanently reserved beds. The Henley Union reserved one bed there and the Reading Borough Council five.

To ensure organized quarterly visits and reports of some responsible person on those who have left the sanatorium, and to supervise the continuance of precautionary measures; to provide assistance when necessary in the home, give instructions and report on sanitary deficiencies.

To direct systematic and thorough disinfection of houses, bedding, etc., from which patients have been removed, or after death, by washing, whitewashing, papering, etc.

Dr. Banks, in opening the discussion, said the total abolition of consumption was an ideal not immediately practicable; still, a great deal could undoubtedly be done. He warned them also against saying that they could cure every case; they could not. They had to consider what would happen to a patient after he returned from the hospital. The man would not be able to do anything like his full work, and every one who knew anything of the labouring classes would know how very difficult it was to get employment for men who could only do light work. All who had watched the work at Madley would know something of what could be done in the way of a sanatorium for working men, but they had to persuade the patient that, even if he had been earning £3 before treatment, it would be better to take 25s. when he came out, and set the other 35s. as an asset in the way of prolonged life. If they were going in for an open-air system of treatment, all that was wanted was wooden buildings, and these could be had for £4 or £5. He also warned them against the fallacy that this system was a quick method of treatment. It would take a very long time and a great deal of money, but it would be of inestimable benefit in carrying forward the work of improving the health of the people. Dr. Collier said the only difficulty seemed to be the question of getting the money. Here he thought they ought to set a certain amount before themselves which was to be raised by private charity before approaching public bodies. Any sanatorium should be co-operative with the patients. Each patient should pay something towards the cost, and he was of the opinion that the families of the poor from the founding of the scheme should pay something as a form of insurance, as was done in other countries, such as Germany. They had also to remember the influence for good a discharged patient would have on the home life. They had found in cases at the Radcliffe Infirmary, where they had not been able to keep patients very long, that the man's return meant a very great stress being laid on the necessity for personal cleanliness at home and other conditions which made for healthiness. As for help from the county council, he supposed there never was a time when public bodies were less willing to spend money. Dr. A. L. Ormerod said what interested him most was the question of prevention. At Brighton there was a system of voluntary notification; cases were sent to the isolation hospital, and the worst of the poorer cases were sent to the workhouse infirmary. They had had very little help from legislation. Paupers were now bound to be notified in cases of tuberculosis, and an order from the Local Government Board for December, 1908, though it gave them hope at the beginning, tied the hands of the medical officers by its later clauses. They could do nothing to stop the spreading of infection. In 1910 compensation would be offered for the slaughter of tuberculous cows; that was all legislation had done to help. The great fault was that men and women would not enter a sanatorium till it was too late. Another difficulty was that they could not get people to believe that consumption was infectious; and—though it seemed a dreadful thing to say, he thought it was true—even if the patients did know that the disease was infectious, they would not care. He had a scheme, though he thought it almost one impossible of realization. He would have a dispensary formed, fully equipped with a staff of physicians and nurses, the nurses ready to follow the applicants to their homes and see to cases there. Then there would be a strong committee formed which would not rest till any houses that were absolutely bad should be done away with. They must educate public opinion, show the people the necessity of dealing with the matter, and teach them to look to the future as the test of the value of their efforts. Dr. Coles said he had always advised the councils to which he was medical officer not to adopt notification. To quote Sheffield as an instance of compulsory notification was peculiarly unfortunate, because Sheffield was a large district which could pass a special law annulling the regulations of the

Public Health Act. In other places they could only place consumption on the list of infectious diseases, with the result that no poor man would be able to avoid being an object of interest, and perhaps dislike, to his neighbours, with the certainty of being unable to carry on his work. The first step must be the establishment of a sanatorium. One should remember the good effect which a man from a sanatorium had; he often developed a real hunger for air, and would sleep out of doors for choice. Dr. Esther Carling thought that the total abolition of consumption was not a counsel of perfection. They had the Local Government Board's statement that it might be hoped that in time phthisis would be as scarce in England as typhus or malaria, and they could point to the general reduction of the death-rate all over the country. There seemed no doubt that people thought a great deal of money had been wasted on sanatoriums in the past, but now a new era was opening. Formerly a sanatorium was supposed to be a place for lounging in easy chairs—a place which taught nothing but idleness. Now the patients were arranged to do work of different value. Professor Osler remarked that there were three things necessary to their campaign: education, organization, and belief that they were going to win. The first of these things was very important, and it could be carried forward by the distribution of pamphlets, by spreading literature, and by means of the tuberculosis van. This van was very successful in its travels about the country; it was fitted up with models showing the treatment of the disease, and carried with it a staff of equipped men who spoke and delivered addresses from the steps of the van. No cause was ever won by being half-hearted, and in this case they could be sure they were on the winning side. The Chairman corroborated the fact mentioned by Miss Price, that in many workhouse infirmaries no treatment was given. A short discussion followed on the best means of carrying forward the propaganda, and it was decided, on the motion of Dr. Collier, to appoint a committee of seven to consider the matter, preparatory to calling a public meeting to support the scheme. Sir Ernest Trevelyan, Miss Price, Professor Osler, Dr. Esther Carling, Mr. V. Watney, Dr. Collier, and Mr. W. H. Ashhurst were invited, and consented, to act on the committee. The Chairman, in proposing a vote of thanks to Professor Osler for arranging the meeting, and to the speakers, said he thought that there could be no doubt that the Council was ready to receive any scheme very sympathetically.

LEEDS.

DEATH OF MR. BLAIR, GENERAL MANAGER OF THE INFIRMARY.

THE death of Mr. Blair will cause a widespread feeling of regret among many generations of former residents at the General Infirmary. Mr. Blair was appointed General Manager of the Infirmary in 1876, at a time when the work of the infirmary was much less extensive than it now is, and, to quote the words of a resolution passed at the weekly board last Friday, "he has watched its growth with the utmost interest, and has himself been one of the chief factors in the large measure of success which has been obtained." Mr. Blair was one of the most loyal servants any institution could possess, while his genial manners and courtesy made him a great favourite with the members of the weekly board, with the honorary staff, and with the resident officers.

THE MEDICO-PSYCHOLOGICAL ASSOCIATION.

The annual meeting of the Medico-Psychological Association was held in Leeds and Wakefield on Thursday and Friday, July 22nd and 23rd, under the chairmanship of Professor Bevan-Lewis, the President of the Association. The meetings were well attended by distinguished alienists from all over the country. On Friday evening the annual dinner of the Association was held in Leeds. Among those present were the Bishop of Wakefield, Sir James Crichton-Browne, Dr. Yellowlees, Dr. Savage, and Dr. Mercier. The University of Leeds was represented by Professor A. S. Grünbaum, and by other members of the teaching staff. In submitting the toast of the University of Leeds, Dr. Mercier referred to the loss sustained by the death of the Marquis of Ripon. He said he was glad to find that he was in error in supposing, as at one time he did, that women were not admitted to the courses of study and to the degrees of the university. His satisfaction on discovering his error was, however, tempered by the discovery that the doors of the General Infirmary were closed to women students, so that they were deprived of the opportunity of availing themselves of the regulations of the university. Professor Grünbaum, in replying, referred to some recent changes in the teaching staff, and with special satisfaction to the retention on the staff of Professor Bevan-Lewis, who by his valuable clinical instruction supplemented the teaching of Dr. Bedford Pierce. Professor Grünbaum held that the recent regulation of the university—whereby a separate paper in mental diseases was abolished and a compulsory question in mental diseases was incorporated with the paper in medicine—was an improvement, and was likely to result in a better standard being maintained than under the old plan of a separate paper. In proposing the toast of "The President," Sir James Crichton-Browne was in the earlier part of his speech reminiscent, dealing with the old times at the West Riding Asylum, and with the improvement which he had seen there during the last forty years. One thing he had done for the West Riding Asylum; he had discovered Dr. Bevan-Lewis, and "tempted him from those Welsh hills where doubtless his heart still was, to the less interesting plains of the West Riding." He paid a graceful tribute to the assistance Dr. Bevan-Lewis had throughout his connexion with the West Riding Asylum received from his wife. The toast of "The Visitors" was submitted by Dr. Yellowlees, and happily replied to by the Bishop of Wakefield.

HOSPITAL FOR WOMEN AND CHILDREN.

The Special Election Committee has promoted Dr. Carlton Oldfield, who for three years has been assistant surgeon to the Hospital for Women and Children, to the full staff in succession to Mr. Walter Thompson, who has resigned on his promotion to the full staff of the General Infirmary.

RESIDENT APPOINTMENTS AT THE GENERAL INFIRMARY.

Mr. H. L. Flint, M.B., Ch.B.Leeds, has been appointed House Physician to Dr. Wardrop Griffith and Mr. S. H. Booth, M.B., B.S.Lond., has been appointed House Surgeon to Mr. Walter Thompson.

BIRMINGHAM.

OPHTHALMIA NEONATORUM.

THE following instructions have been issued by the Health Committee to all the midwives in Birmingham with reference to infantile ophthalmia. The instructions are largely copied from those drafted by the British Medical Association in the special report on the subject.

INFLAMMATION OF THE EYES IN YOUNG INFANTS (OPHTHALMIA NEONATORUM).

The above disease accounts for more than 10 per cent. of all cases of blindness, and over one-third of all the cases of blindness in blind schools are due to this disease. If taken in time the disease is curable. Midwives are required to observe the following directions:

I.—*Treatment of Cases presumably Normal as regards Danger of Ophthalmia Neonatorum.*

CHILD.—In every case in which a medical practitioner is not in attendance the midwife shall adopt the following routine procedure:

(i) Directly the head is born, and before the eyes are opened, the lids and the surrounding skin should be wiped clean on each side with a separate piece of sterilized wool.
(ii) Nothing should be dropped into the baby's eyes.
(iii) The face and the body should not be washed in the same water. Fresh water should be taken for each.

II.—*Treatment of Cases in which the Mother Suffers from a Purulent Vaginal Discharge.*

(*a*) MOTHER.—If there is a purulent vaginal discharge, whether in pregnancy or labour, medical help must be obtained.

(*b*) CHILD.—If a doctor is not already present when the child is born he should be sent for immediately, in order that any necessary application to the child's eyes may be made.

III.—*Procedure where an Affection of the Child's Eyes is Observed.*

If there is any inflammation of the baby's eyes, however slight, shown by redness, swelling, or discharge, the midwife or

nurse must explain that the case is one in which the attendance of a registered medical practitioner is required, and medical help must be obtained in accordance with the rules of the Central Midwives Board.

N.B.—Failure on the part of a midwife to act promptly in reporting any case of inflammation of the eyes will be deemed to be a serious offence by the Health Committee.

The Health of Birmingham.

The health of Birmingham, with the exception of a widespread and very fatal outbreak of measles, has during the last six months been good. The birth-rate was 27.8 per 1,000 as compared with 29.7 during the same period last year, and the death-rate was 17.7 as compared with 17.2 in the first six months of 1908, and an average of 18.5 in the previous ten years. A very fatal type of measles began to be prevalent during November last, and the infection was diffused over the whole city during the period when the weather was coldest. The mortality was very high, for no fewer than 503 children died from the disease during the half-year under review; of these, 97 were under 1 year of age, 210 between 1 and 2 years of age, 91 between 2 and 3, 51 between 3 and 4, 22 between 4 and 5, and 32 over 5. The deaths from the other infectious diseases were: Small-pox, 0; scarlet fever, 40; diphtheria, 56; whooping-cough, 97; typhoid fever, 5; epidemic enteritis, 44. The number of cases notified under the Infectious Disease (Notification) Act was: Small-pox, 0; scarlet fever, 1,125; diphtheria, 382; typhoid fever, 40; puerperal fever, 15; erysipelas, 246.

The health of Birmingham at the present time is exceptionally good. The total death-rate last week was equal to 10.6 per 1,000 per annum of the population, as compared with 11.5 in the previous week. A death-rate of 10.6 is the lowest experienced in Birmingham since the week ended August 3rd, 1907, when the rate was equal to 10.5 per 1,000. The lowest death-rate last year was 10.8, and was recorded for the week ended July 25th. At the end of last week there were 334 patients in the scarlet fever hospital, 33 in the diphtheria wards, and 4 in the typhoid fever pavilion.

Birmingham Lunatic Asylums.

The report of Dr. Whitcombe upon Winson Green Asylum shows that in 1908 there were admitted 453 patients, discharged 391, died 114, leaving 638 in the institution at the close of the year. The number of admissions was equal to about an average for the last ten years, and the number of those discharged was increased by the removal of 50 males and 70 females to Rubery Hill Asylum. It is satisfactory to note that an increased proportion was discharged recovered, the recovery-rate for the year upon the number of admissions reaching 50.7 per cent. The death-rate was again high and was considerably raised by many patients being sent to the institution in a practically dying condition. No fewer than 12 males and 8 females were received in such advanced stages of physical disease, other than brain disorder, that they survived only a few days, most of them having suffered for long periods before admission. The report of Dr Suffern upon Rubery Hill Asylum shows that the number of patients at the beginning of 1908 was 1,343, admitted during the year 121, discharged 108, died 68, remaining in the institution at the end of the year 1,288, average number resident 1,310. The average age of those admitted was 40, the ages ranging from 4 to 71 years. Among the forms of mental disorder on admission were 24 cases of congenital mental deficiency, 17 cases of epileptic insanity, and with one exception the remainder were chronic cases. Of those discharged two had recovered, two were relieved, and the remainder had not improved. The death-rate was again low, the percentage of deaths on the average number resident being 5.19, as compared with 10.1 per cent. for borough and county asylums during the year 1907. Neither seclusion nor restraint had been resorted to during the year.

Hospital Saturday Fund.

The present year's collection amounts to £19,041 from 2,045 contributors, as against £20,163 from 2,084 contributors at the corresponding date last year. This is a decrease of £1,122 in amount, and of thirty-nine in the number of contributors. The falling off in the collection is undoubtedly due to the very bad trade that has existed throughout the city. It has not been confined to one branch of trade, but seems to have affected all trades. This being the case, there is no reason to regard this year's drop in the Hospital Saturday Fund collection as anything more than a temporary vicissitude, due to causes altogether beyond the control of those who have the direction of the movement. Now that the annual collection is past, renewed efforts will be made on behalf of the Sir William Cook Memorial Fund for Consumptives. Something like 10 per cent. of the factories have already paid contributions to this fund.

WALES.

The Ebbw Vale Dispute.

The following announcement appears in the *South Wales Daily News* of July 20th:

The Ebbw Vale Doctors' Fund question was the subject of arbitration proceedings at the Town Hall, Newport, on Monday. The arbitrators were Mr. Alexander Wilkie, M.P., for the Board of Trade; Mr. Richard Bell, M.P., nominated by the Cwm workmen; and Mr. Arthur Henderson, M.P., nominated by the Fund Committee. Since 1894 there has been a difficulty between the Ebbw Vale and Cwm sections of those contributing to the fund with regard to the conditions under which the doctors have served the Fund Committee. The Cwm section specially raised the question of the dismissal of Dr. J. O'Sullivan, and after protracted negotiations it was decided to refer the matter to arbitration.

Several witnesses were called, and in the evening the arbitrators announced they were of opinion that Dr. O'Sullivan and others were legally dismissed by the committee under the powers provided in Rule 10.

The same newspaper in its issue of July 24th says:

The fact that a section of the payees at Cwm had decided to throw over its leaders and form a new committee to carry on the fight in connexion with the Ebbw Vale Workmen's Doctors' Fund dispute, and to ignore the findings of the arbitrators at Newport, has complicated the situation. Yesterday our representative called upon Mr. Tom Rees, secretary of the fund, who said the action of these men in throwing over the old leaders and repudiating the award of the arbitrators had arisen from thoughtlessness. He was sure if the men had the slightest knowledge of the real position they would now drop the whole matter. They were assisting the British Medical Association to fight their fellow-workmen. He hoped the Cwm men would give the question their earnest consideration, and not let the interests of one man be opposed to the welfare of the community.

Swansea Hospital.

At a meeting of the Swansea Hospital Board held on July 21st, Mr. John Dyer, one of the greatest benefactors of the institution, was unanimously elected chairman.

Patti and Cardiff Infirmary.

Intimation has been received by Dr. Howell Rees from Madame Patti that she will sing at a concert in Cardiff in aid of the infirmary on September 8th. The announcement that the Baroness Cederstrom had consented again to help the institution was first made in January last at a meeting of the Infirmary House Committee, but at that time the date of the concert had not been fixed.

Water for Western Valleys.

A conference of the local authorities of the Western Valleys of Monmouthshire was held at Newport Town Hall on July 21st to consider the provision of an adequate supply of water for the district. There were present representatives from the Abercarn, Abertillery, and Risca Councils. The Mynyddislwyn Council wrote stating that as they had arranged with the Tredegar Council for their water supply they did not consider it expedient to send representatives to the conference. After a lengthy discussion it was resolved to visit the site of the Grwyne Fawr stream, in the north of the county, and the conference was adjourned for a month.

A Former Cardiff Bacteriologist.

The Somerset County Council having decided to appoint a medical officer of health at a salary of £700, rising by yearly increments of £20, the committee to whom the appointment was left selected Dr. William G. Savage, who has been Medical Officer of Health for Colchester since March, 1903. For three years before that time Dr. Savage was Lecturer in Bacteriology at the Cardiff Medical Schools, and Bacteriologist to the Cardiff and County Public Health Laboratory. During his stay at Cardiff

Dr. Savage made a large number of friends, to whom the news of his new appointment has been most gratifying.

Swansea Lupus Patients.

On July 22nd it was announced that Miss Dillwyn had made a gift of £1,000, which will yield £40 per annum, for the purpose of sending necessitous patients suffering from lupus to special hospitals for treatment. The Swansea Ladies' Samaritan Society will have charge of the fund, and it is the wish of Miss Dillwyn that guardians who know of sufferers from this disease shall notify this Committee. At a meeting of the Workhouse Committee of the Swansea Board of Guardians the chairman made the announcement, and a member said the guardians had reason to be proud of the generous spirit shown by Miss Dillwyn. In the course of her investigations as a guardian she had realized the ravages this fearful disease was causing. Several others expressed appreciation, and Miss Dillwyn said the best appreciation that could be shown would be to bring before the notice of the society deserving cases.

Nursing Association.

The Lord Mayor of Cardiff presided at a meeting at the Law Courts on July 24th, when it was decided to establish a Nursing Association for South Wales in affiliation with Queen Victoria's Jubilee Institute of Nurses, in order to provide for the training and supply of village nurse-midwives for the rural districts of South Wales. Amongst those present was the Marchioness of Bute (who convened the meeting) and several other ladies of note. Miss Hughes (general superintendent of the Jubilee Institute for Nurses) explained that the object of the association would be to help to provide for, and further develop and increase the efficiency of district nursing throughout South Wales; to arrange for the training of village nurses and their supply to local nursing associations that could not afford to employ a more highly trained nurse, etc., and to approach the various local public administrative bodies for financial assistance towards the training of nurses and midwives. Lady St. David's moved a resolution that the South Wales Nursing Association should be formed; this was carried *nem. con.* Rules to govern the work of the Association were adopted, and the Provisional Committee for South Wales was formed, with power to add to their number. The president is the Marchioness of Bute, with Mrs. Alan de Rutzen as honorary treasurer *pro tem.* and Lady St. David's honorary secretary *pro tem.*

Presentation to Dr. T. E. Richards.

The inhabitants of Abercrave, Brecon, and district recently presented Dr. T. E. Richards, J.P. (Medical Officer of Health to the Ystradgynlais Rural District Council), with an illuminated address, diamond scarf-pin, and gold chain. Mrs. Richards was also presented with a diamond ring, a pair of silver candelabra, and a case of cutlery. In the afternoon 550 persons partook of a tea provided by Dr. and Mrs. Richards at the council schools. The evening meeting was presided over by Councillor D. R. Morgan (Abercrave), who said that the workers of Abercrave had organized the presentation to signalize Dr. Richards's appointment to the commission of the peace for the county of Brecknock, as well as to show their regard for the doctor, who during the nine years he had been among them had won the respect and esteem of all.

Ireland.

[From Our Special Correspondents.]

Protest against a Proposed Sanatorium at Dalkey.

On Monday last a deputation of members of the Dalkey Urban Council waited on Lady Aberdeen, to protest against the utilization of the Coastguard Station as a sanatorium for consumptives. The substance of the address was given in the Journal of July 31st, p. 294.

Dr. Wright, Medical Officer of Health, said if they had a consumption hospital placed there the fate of Dalkey as a health resort would be sealed.

Lady Aberdeen said the deputation was under somewhat of a misconception, as there was not a definite idea of starting a sanatorium at the Dalkey Coastguard Station. As far as coastguard stations generally were concerned they could not be considered suitable for consumptives in advanced states. Every case would be submitted to medical examination so as to render it sure no danger would be created. But they felt so great a need existed in Ireland for preventive work, that it seemed a crime not to take advantage of buildings in the most healthy position in Ireland. Some people were afraid that the antituberculosis movement was creating a scare injurious to the country, but she appealed to the deputation and to the country to help to dissipate this scare.

After much discussion Dr. Wright said the place should only be used as a holiday home,

Lady Aberdeen said they were under a misapprehension. People who went there would not be consumptive.

It was finally agreed that the building if acquired should be used as a holiday home for tired workers, and that no cases of pulmonary tuberculosis should be sent there.

Irish and the National University.

At a recent meeting of the Senate of the newly-established National University, Archbishop Walsh, Chancellor, in the chair, the question of compulsory Irish was brought forward by Dr. Hyde in the form of a resolution, that the Senate should ordain

> That a suitable proficiency in the Irish language and in the history of Ireland should be required for all candidates for entrance, and for the non-specialized courses of the university.

This was ruled out of order, inasmuch as it called on the Senate to make a regulation relating to examinations which the Senate was expressly prohibited from making without report from the General Board of Studies, and the General Board of Studies could not exist until after the dissolution of the Royal University.

In reply to a request from the Irish County Councils' General Council that the Senate should receive a deputation urging that the Irish language should be made an essential subject in the programme of the university, the Registrar was directed to state that, under the provisions of the Charter, no matter connected with the curriculum or subjects of examination of the National University could be effectively considered until the General Board of Studies shall have been constituted, which board could not be constituted until after the dissolution of the Royal University—that is to say, until some date probably not earlier than the end of October—and to add that the Senate would be prepared to receive the deputation at the first meeting held after the dissolution of the Royal University.

Special Correspondence.

VIENNA.

Post-graduate Lectures in August and September.—Control of Midwives.—Disinfection in Vienna by the Municipal Works.

The summer term of the University of Vienna ends in a few days, and with it the official lectures and classes will cease. For some years back the assistants in the clinical wards and the *Privatdocenten* have made use of the two vacation months for the holding of special classes for graduates from all universities. These classes comprise theoretical and practical teaching of certain branches. They extend over four weeks, one lecture being given every day, and cost generally about £4 4s., whilst the number admitted to the class is mostly limited to 10. Surgery, anatomy, bacteriology, otology, rhinology, pathology, and ophthalmology are the main subjects taught. The classes are unofficial, in so far as they are not conducted with the special authorization of the Senate; but they are as good as any others, and even more appreciated on account of the good opportunities offered by them to students to study the cases. The fact that the clinical lectures are suspended enables the teacher to select cases from the entire clinic. As a rule, some classes are conducted in English, especially those arranged by the Anglo-American Medical Society in Vienna.

Since the appointment of a new official to the post of Chief Inspector of Health in the Ministry of the State (Home Secretary), his attention has been directed to the

state of affairs of midwifery in this country. At present a curriculum of not longer than six months is sufficient to enable a woman to style herself midwife. In some country places the title is adopted without any other studies than the teaching obtainable from another equally "qualified" matron. The number of medical practitioners is not sufficient to check any harm done by such women, and in spite of all the drawbacks of the system popular belief is not easily corrected; therefore the medical profession has learnt with satisfaction that a reform of the course of studies for midwives is contemplated. A curriculum of two years, three months' theoretical and nine months' practical work in each year, has been fixed as a minimum. The studies must be pursued in certain midwifery clinics, of which there will be seven in Austria. An examination has to be passed before a diploma is granted, and no one may assume the title of "midwife" unless she can produce this diploma. The district officers of health will in future be required to control the midwives of their districts by frequent surprise visits, and once a year at least a meeting of the midwives of a district will be held, with the officer of health in the chair, to enable him to make the women acquainted with anything important concerning their avocation. A case of puerperal fever incapacitates the midwife in charge for a period of at least eight days after her last attendance, and this measure will be one of the most strictly enforced under the new regulations. The midwives now at work will have to undergo an examination comprising the fundamental principles of asepsis and obstetric work, and the first care of the newborn babe, unless they already possess a proper diploma. The instillation into the eyes of two drops of a solution of nitrate of silver or protargol, according to Credé's method, will be made compulsory for each midwife in every case of delivery of a living child. The efficacy and harmlessness of this treatment has been proved in many thousands of cases in the maternity wards in this country.

Following the erection of a new disinfection plant in the city, the municipal board of health has since last year taken over all disinfecting operations within the city of Vienna, and the following rules have been laid down for those employed in the work. The disinfection is to be effected either by steam or by formaldehyde gas with steam or with the gas alone. Plague, small-pox, and anthrax require a thorough disinfection of all articles contained in the house inhabited by the patient with formaldehyde and steam. Diphtheria, scarlet fever, whooping-cough, and typhoid fever are termed second-class diseases, requiring a thorough steaming or a large quantity of formaldehyde. Houses with measles, German measles, influenza, mumps, blackwater fever, or dysentery must be treated only with formaldehyde. Excretions and bandages must be destroyed, or, if this is impossible, must be placed in carbolic lotion (5 per cent.) or oxycyanide of mercury 2 per cent., and then brought away. All medicines, food, and articles of personal use must be destroyed, and on no account are they to be thrown into the watercloset without being well mixed with carbolic or the oxycyanide. Books, toys, and papers must be burnt. The men employed in the work must wear special garments, which have to be placed in the disinfection apparatus as soon as they are taken off. Each man has, in his turn, to submit to a strict cleansing process, including hair cutting and a bath, when his work is done. The number of disinfections has increased in the last year owing to the fact that all this work is done free of charge in every case of notified disease, and the people have found out that it is the safest course, in spite of the discomfort it may bring upon the individual. On an average twenty-five disinfections are done daily. The costs are comparatively low, each disinfection costing not more than about 2s. 6d. per room. The expenses are defrayed from the rates and taxes paid by the citizens.

Miss Mary Howard, formerly of Southborough, Tunbridge Wells and Bournemouth, recently deceased, has left £1,000 to the Cancer Research Fund, £500 each to St. Peter's House, Woking, for the endowment of a bed in the Children's Ward, the Surgical Aid Society, the National Society for the Prevention of Cruelty to Children; and £250 to the Society for the Prevention of Cruelty to Animals.

Correspondence.

THE REPORTS OF THE POOR LAW COMMISSION.

Sir,—While expressing my entire sympathy with Dr. Vipont Brown with regard to his remarks on the provident dispensary scheme of the Majority Report, I fear I must join issue with him about the Minority. He says:

> What does it matter whether or no the scheme involves gratuitous treatment for all applicants, provided we are well paid?

That reservation is a very important one! What one party considers good pay often differs a good deal from the views of the other. Dr. Brown has a wonderful faith in the State as a paymaster; possibly he has not had much experience of State service. He might usefully study your article in the Journal of July 24th relating to the Indian Medical Service. The civil surgeon there spoken of might be regarded as a type of the Minority State doctor, except that he does not appear to have the use of a State motor car. The 500 rupees a month, making allowance for the depreciation on the silver currency and the enhanced expenses of Indian life, would work out at about £300 per annum in this country. If the proposed State doctor got £250 a year he would be considered extremely well paid by most of the supporters of the Minority Report. The President of the Local Government Board himself once publicly expressed his inability to comprehend that any man's work could be worth more than £500 a year.

On the whole I cannot help thinking that, bad as general practice may be in many cases, it is better for our brethren to trust to the munificence of the public than to the State. At least, as a general practitioner he possesses an independence that no State official can claim. He is not bound hand and foot by red tape; and I agree with Dr. Downes that it would be a bad day for the public when the natural independence of the medical profession was exchanged for any system of nearly universal officialism.—I am, etc.,

London, N.E., July 24th. Major Greenwood.

CANCER RESEARCH.

Sir,—I regret exceedingly that Dr. Drage should think that I have in any way slighted him; but the fault, if there be one, lies not with me, but in the impossibility of any one reading all that is written. On two occasions at least I have given Dr. Drage credit for his work in connexion with the treatment of cancer, and it would really be impossible, when writing or speaking of any drug or treatment, to always "couple with the name of Dr. So-and-So."

Besides, I brought forward a principle, and the practice was somewhat incidental; and I expressly excluded the treatment of cancer by cinnamate of sodium when I said that no one drug was sufficient to carry out the principle I advocated—namely, that of regulating treatment by the improvement or otherwise in the condition of the blood.—I am, etc.,

London, W., July 27th. Skene Keith.

THE CAUSE AND PALLIATIVE TREATMENT OF ENLARGED PROSTATE.

Sir,—Will you kindly allow me to make a remark or two on these subjects, concerning which the last few numbers of the Journal contained something anent? It is the fashion now to attribute senile enlargement to inflammation, and consequent infection. As clinical evidence is mentioned, I would like to say that the theory is unsupported in my opinion. For many years I have worked at statistics, and I have found this condition quite as common—in fact, I believe more common amongst those who never had urethritis, or even the chance of getting it! This inquiry embraced personal experience in urban and rural districts far and wide, and information got from rural practitioners. The disease is common even amongst the celibate clergy.

Amongst 1,000 persons the subject of the disease, one-fourth only had had urethritis. Chronic prostatitis, more often than not, culminates in fibrotic change, a state rather antagonistic to glandular proliferation. The initial step of senile prostate may be prostatitis. It is the expression of congestion, not urethritis. We do not very

commonly find stricture where infective states are marked in company with the senile gland. Moreover, I have met the latter in old dogs, and these are not the subjects of urethritis in the usual sense.

Mr. Herring's article is apt and praiseworthy, but is not asepsis too big an idol? Every one knows what the anterior urethra contains, and he does not tell us how to fight the flora. The absence of trauma is more important than even asepsis, and, if he takes away the rubber catheter, he takes the old man's best aid. A rubber catheter and a spittle are better than a hard one clean from the fires of the gods. Pliability, as I often pointed out, when disadvantageous can be remedied by a thin whalebone or other stilette bent at the tip, if desired, to constitute a coudé. Do not oil the catheter; inject some antiseptic mucilage into the urethra. All this involves no trouble.—I am, etc.,

London, E.C., July 18th. JAMES MACMUNN.

RECEIVING HOUSES FOR INCIPIENT MENTAL DISORDER.

SIR,—I have read with much interest the communication regarding this matter in the JOURNAL of July 24th.

The proposal seems to me a very good one, and should be universal, not limited to London.

For many years I have had occasionally to deplore the want of an institution intermediate between the home and the asylum, and I have no doubt it is a general experience.

Most mental cases in their early days would benefit by removal from their usual surroundings, but naturally enough the patient objects to be sent to an asylum, as this word is associated in his mind with all that is dreadful. The family objects on the same grounds, as well as on account of the stigma attaching to this treatment. The result is that the case grows worse, and sometimes ends in disaster, which might have been entirely prevented.

Occasionally the patient himself seeks removal to a place where he knows he will be safe and properly cared for. This, of course, occurs only in the earliest stages, when the mind is only unhinged. Personally I have had more difficulty with the family in such cases than with the patient, for he can sometimes be convinced of the value of special treatment. The friends cannot be made to understand that a lunatic asylum is a hospital for the cure of mental disorder, and not necessarily a place for the permanent detention of incurables. This is the real reason for their refusal to allow those who are only slightly affected from having the chance of being cured. They regard the asylum as penal servitude for life, and the doctor who suggests it is treated accordingly.

This is why mental cases are kept at home until they are hopelessly ill, to the detriment of all concerned. The presence of such a person at home is detrimental to other members of the family, especially to any one who may be morbidly inclined, as all experienced doctors know.

Home treatment is impossible on account of the expense, even if all other things are favourable. There is not one house in a thousand where these are favourable. I have urged that a mental disorder requires treatment like any other illness, that there are hospitals for the treatment of the bodily sick, and that there are asylums for the treatment of the mentally sick.

It is no use telling people that an asylum is a large building with facilities for the classification of cases; they think and aver that the mild cases are associated with the severe ones, and suffer in consequence.

What we want is an institution with a name different from asylum—call it hospital for mental diseases, or mental sanatorium, or nursing home, or institution for mental illness, or something else—where the charges would be moderate.

The private hospital and public receiving house, such as is proposed for those who are paid for by the rates, could be combined in one institution if the departments were kept separate and distinct.—I am, etc.,

Manchester, Aug. 2nd. F. W. JORDAN, M.D.

THE POSTMASTER-GENERAL AND THE MEDICAL PROFESSION.

SIR,—I am obliged to Dr. Mason for the courteous tone of his letter in your issue of July 31st, and I hope I shall say nothing in the course of this discussion—which I look upon as of the highest importance to the medical profession as a body—that might be considered in the smallest degree, as of a personal character. In this connexion, when I used the word "slave," I did so in no derogatory sense. I myself happen to hold an official appointment, and in that respect am a "slave." Further, it is my privilege to know a great many practitioners who hold Post Office appointments, and I can say with truth that one and all have been well chosen and hold most worthily the position in which they have been placed.

Now, Sir, in venturing to address you on the subject of Post Office appointments, I did so on what I well knew was a partial and incomplete view of the situation. This particular aspect of the question had remained fixed in my mind since the time, now long ago, when as a member of the General Medical Council I had the best opportunities of studying, in connexion with the actions of friendly societies, the whole matter of contract practice, not without much consideration and attempts at finding some final solution of the many difficult and complicated questions connected with the relation of those bodies to their doctors did I come to the clear conclusion that *all* contract practice is essentially bad, and, wherever possible, ought to be condemned and abandoned.

In seriously considering the necessity for selecting certain practitioners for the office referred to, and in a broad view of the subject there are four essential points to keep in mind:—

First, the work to be done and its proper supervision and regulation.

Secondly, the qualifications of those chosen for the posts of medical officers.

Thirdly, the interests of the medical profession as a body; and

Fourthly, the feelings of the Post Office men themselves.

As regards the first head it is quite evident that those who aspire to be medical officers to the Post Office must be possessed of certain necessary qualities for the work. They would have to be of at least some two or three years' standing, and their character and respectability would have to be vouched for, amongst others, by two or more of their medical brethren who were in a position to speak of them from intimate knowledge. Again, the candidate would have faithfully to promise to obey all reasonable orders issued by the Postmaster-General. Further, he would have solemnly to engage to do his duty fairly and impartially as between his patients and the department at the risk of being immediately dismissed from the service if he acted in a different spirit.

Coming to the second head in the order suggested. In the first place I wish to state that however anxious I am for reform in the mode of making a selection from *future* candidates for these posts, I would never for one moment think of disturbing the present holders from their position. As I have said, all that I know convinces me that they have been well chosen and are eminently fitted for their posts. But I humbly think—and I speak from having, as a matter of fact, deliberately chosen the course I am recommending—that it would tend to sweeten one's relations with his neighbours if a little self-denial were oftener practised in accepting such appointments.

In discussing the question we are considering under the third head—the interests of the profession as a body—I have already referred to the evils of contract practice. And here I would like, with your permission, to enter a protest against the views of my friend Mrs. Sidney Webb and those members of the late Poor Law Commission who advocate what I must call the Socialistic doctrine of State-supported and State-managed doctors. *Quis custodiet ipsos custodes?* I hold that medical skill and attention can *never* be weighed and measured, and that it would be fatal both for the doctor and his patient to attempt to gauge such imponderable entities by the agency of lay inquisition, however impartial they were disposed to be. And so I say let the doctor and his patient, the Post Office official, settle between themselves whether they will continue to hold that intimate relationship, or resolve to drop it, and let another practitioner, as in daily life, try *his* hand. Surely, Sir, the parties to the contract will not willingly resolve to part; but the freedom of the chain which binds them—that of mutual regard and respect—

will be less galling than a hard-and-fast bond of enforced services.—I am, etc.,

Dingwall, N.B., Aug. 3rd. WILLIAM BRUCE.

PS.—A word as to the numerous duties of the Post Office medical officer mentioned by Dr. Mason. Sanitary matters, if I may be allowed to speak as a medical officer of health, belong to the province of the local authority; and again, speaking from personal experience, for all the good that statistics yield, any well trained practitioner is surely able to furnish and complete the necessary information required. W. B.

SIR,—In your issue of July 31st Dr. Mason "fails to see why the present system of medical appointments by the Postmaster-General is radically bad."

He must be well enough aware that the position in most cases is gained through political influence, irrespective of the qualification of the different candidates, or without considering the wishes of the Post Office employees to be served.

The employees are placed on a lower level than the penny a week club patients, who can retire without losing their occupation, whilst the poor Post Office official by retiring loses his means of livelihood. The present system is indefensible.—I am, etc,

August 2nd. OBSERVER.

SIR,—May I add to the voices raised over the Postmaster-General and the medical profession one more?

Recently a medical man got the Post Office appointment here, where there are other medical men, who had attended as chance had it up to that time the Post Office officials. I suppose others like myself find that they are in process of losing patients through this change which we are forced by taxation to pay our share of. The only solution of this is Dr. Bruce's, and the letters of the President and Secretary of the Principal Medical Officers' Association are beside the mark and selfish.—I am, etc.,

July 31st. SOCIALIST.

THE DRINKING CHILD.

SIR,—In your review of *Die kindliche Psyche und der Genuss geistiger Getränke*, by Leopold Lang (BRITISH MEDICAL JOURNAL, February 6th, 1909), you said:

> To what extent juvenile drinking obtains in our country we do not know. Accurate information on this point would be valuable, particularly if at the same time the educational results could be obtained and compared from this point of view. We imagine, however, that in this country juvenile drinking is of infrequent occurrence, and that in this matter, at least, we can say, "Let the galled jade wince, our withers are unwrung."

Dr. Imre Dóczi, the representative of the Hungarian Government at the 12th International Congress on Alcoholism, read a paper on "Alcoholism and its effects upon the child." The original paper was written in his native tongue, and was subsequently translated into German and thence into English, with the result that an unfortunate error crept in and he was made to say in the published abstract that:

> As a result of statistics gathered it is found that there are hardly any schools in which there is a pupil who is a total abstainer. On the other hand, it is by means rare to find schools where there are not pupils who do not have alcohol given to them in some form by their parents.

He has requested me to ask you to correct the error, and to state that what he intended to convey was that:

> Most carefully prepared statistics based upon the data obtained by the Hungarian Government as to the drinking habits of all the children—that is, about half a million children under the age of 18, in all the schools of all classes, both elementary, private, and public, show that 20 per cent. of the children are total abstainers. It is by no means rare to find schools where pupils are given alcohol daily by their parents. Among the poor Slav population this is given in the form of spirits distilled from grain, or possibly more commonly from potatoes.

The investigation was carried out in a very thorough manner, and it was found that 36 per cent. of the pupils who indulge in alcoholic drinks were careless and idle, 11 per cent. dull of comprehension, 13 per cent. incapable of prolonged attention, 10 per cent. during the first hours of the morning (from 8 to 9) gave confused answers, 18 per cent. were very backward in subjects requiring special mental effort, while only 10 per cent. showed no ill effects. The statistics show, further, that alcohol has a marked influence on mind, character, and bodily health. In only 3 per cent. of the cases had a doctor prescribed alcohol for the child.

These facts may be taken as valuable evidence of the necessity for similar research in England. Some months ago I obtained figures from a few of the London County Council infant schools, and found that, in each, no less than 40 per cent. of the infants under 8 years of age drank alcohol more or less regularly. There appears to be no doubt that a similar state of things exists in every part of Christian Europe, except in the countries of the farthest north, and it would be interesting to find out whether the figures I obtained from schools chosen haphazard are true of the rest of the country. In one school of some 300 infants I found that 11.8 per cent. drank alcohol daily, 34.1 per cent. drank occasionally, and 54 per cent. were "band of hope," but I know of one "band of hope" child in another school who drinks alcohol daily.

The medical inspectors of school children already have power to obtain this information, and it is to be hoped that during the course of the next few years some such inquiry will be made into the drinking habits of the children in this country.—I am, etc.,

Norwood, July 28th. F. G. MACKERETH.

THE MEDICAL TREATMENT OF SCHOOL CHILDREN.

SIR,—The attention of my committee has been drawn to the statement in the published report of the meeting of the Education Committee of the London County Council, held on July 14th, contained in the issue of the BRITISH MEDICAL JOURNAL of July 17th, p. 156, that:

> The Paddington Green Children's Hospital will take 20 ophthalmic cases a week.

I am requested to inform you that this statement is incorrect, and that no such offer has been made from this hospital.—I am, etc.,

W. H. PEARCE,
Secretary.

Paddington Green Children's Hospital,
London, W., July 23rd.

HOSPITAL OUT-PATIENT DEPARTMENTS.

SIR,—The figures given in the letter under this heading (JOURNAL, July 10th, p. 109) are truly a revelation. How far the medical staffs of the hospitals, the private practitioner, and the public are to blame for such a state of affairs it is difficult to decide, but all three are guilty.

The profession has the matter in its own hand, and if every would-be hospital patient seeking charity were required to produce a certificate stating that he or she is a suitable case for charitable treatment, signed by a medical practitioner, I think abuse and misuse of charitable institutions would be greatly diminished.

There is no doubt that the profession—the medical practitioner on the one hand and the medical hospital staff on the other—ought to exercise more care in recommending and in admitting patients to charitable treatment. Charity at all times requires very careful supervision, and in no quarter is that more necessary than when doling out charitable treatment to patients.—I am, etc,

FORMER RESIDENT HOUSE-SURGEON, HOUSE-PHYSICIAN, AND EXTERN SURGEON.

July 14th.

INSTRUCTION OF DENTAL STUDENTS IN ANAESTHETICS.

SIR,—With regard to the letter in the JOURNAL of July 17th on the instruction of dental students in anaesthetics, it is quite evident that the council of the Royal College of Surgeons of England are wholly unfamiliar with the conditions prevailing in some parts of the United Kingdom as regards anaesthetics employed for dental operations.

For instance, in Scotland $CHCl_3$ is still employed very often when some minor and safer anaesthetic agent would be preferable. It may be said to be in common use—in country districts, if not so much as formerly in the larger cities. Ethyl chloride is frequently given by dentists themselves, when single-handed. Surely it is not the desire of the council to perpetuate this sort of thing. It should rather be the aim of the regulations they frame as

well as of any new anaesthetics bill to put an effectual embargo on this class of practice—whether the anaesthetic be given by a dentist or medical practitioner.

Probably no single man has contributed more good educational work, so far as the administration of anaesthetics by dentists is concerned, than Mr. Guy of Edinburgh. It has been his invariable practice to induce only a brief anaesthesia by means of nitrous oxide and ether, or nitrous oxide and ethyl chloride, and by training students to do extractions very rapidly enable them to accomplish as much as possible in the time afforded—possibly one and a quarter to two minutes. If more be required, the patient returns another day. Nothing has done more to improve the technique of dental anaesthesia in Scotland and many parts of the English provinces where Scottish students settle than this.

And nothing has done more to put an end to the reckless and unjustifiable use of chloroform in dental operations. Personally I can see little objection to the dental student being so trained, and many advantages. The poorer classes thus get better treatment and comparative safety. Of course, the ideal—at which Dr. Hewitt would appear to aim—is the presence of a fully-trained anaesthetist or a well-trained physician, but the ideal is usually unattainable—and it certainly is so here.

In the present mixed-up state of medical education as regards anaesthesia, it is certainly much more difficult for a medical student to be adequately trained in the minor anaesthetics than for a dental student. Looking farther ahead, one sees the time coming when the dental and medical professions will be more closely welded than at present, and the medical side of the dental curriculum considerably extended—even to equalling that of the medical practitioner to be.

It would seem better, therefore, on cool reflection, that the efforts of those working in the department of anaesthetics should be directed not to restriction of the dental surgeon's powers and training, but to the framing and pressing forward of such a legal enactment as will secure a good training in anaesthetics all around—a compulsory training—and so lessen malpraxis; further, to make the use of any anaesthetic agents of a toxic nature, local or general, by the unqualified quack and impostor, an offence punishable by fine or even imprisonment.—I am, etc.,

Peebles, July 21st. T. D. Luke.

Universities and Colleges.

UNIVERSITY OF EDINBURGH.

The Professorship of Anatomy.

On July 29th the Curators of the University unanimously appointed Dr. Arthur Robinson, M.D., Professor of Anatomy in the University of Birmingham, to the Chair of Anatomy in Edinburgh University, rendered vacant by the death of Professor D. J. Cunningham. Professor Robinson studied at the University of Edinburgh, where he graduated M.B., C.M., with honours in 1883. In 1890 he proceeded to the degree of M.D., being awarded a gold medal for his thesis, which embodied the results of original investigations upon "The Development of Rodents." For a number of years he was on the teaching staff of Owens College, Manchester. In 1895 he was appointed Lecturer on Anatomy in the Middlesex Hospital Medical School, and in 1900 he was appointed Professor of Anatomy in King's College, London. He was Secretary of the Board of Intermediate Studies of the University of London, and was actively associated with the movement which resulted in the formation of the Board of Human Anatomy and Morphology by the Senate of the University of London. In 1904 he was elected to the Chair of Anatomy at Birmingham, and in 1905 he was appointed Sub-Dean of the Medical Faculty. In the summer of 1903 he was appointed Hunterian Professor by the Council of the Royal College of Surgeons of England. He has also been Examiner at Oxford and elsewhere. Professor Robinson has made many valuable contributions to the literature of his science; among them may be mentioned papers on the Position and Peritoneal Relation of the Mammalian Ovary; the Nutritive Importance of the Yolk Sac; the Formation and Structure of the Optic Nerve and its Relation to the Optic Stalk; the Development of the Pericardium; and the Comparative Anatomy of the Ova and the Placenta in Mammals—all of which appeared in the *Journal of Anatomy and Physiology*.

QUEEN'S UNIVERSITY OF BELFAST.

Departments of Physiology, Pathology, etc.

To provide for the expected larger demands upon its resources next session the senate has sanctioned the expenditure of £1,500 on the provision of better equipment for the departments of physiology and pathology, pathological laboratory, physics, chemistry, zoology, archaeology, anatomy, botany, and geology.

Graduates of the Royal University.

A notice has been issued to graduates of the Royal University of Ireland who are entitled under the Act to join the Queen's University, and an application form for the purpose has now been sanctioned by the senate, and will be sent to any such graduate by the registrar on application.

Officers' Training Corps.

The university contingent of the Officers' Training Corps went into camp at Ballykinler on July 31st for a fortnight's training. The Commander-in-Chief in Ireland (Sir Neville Lyttelton, G.C.B.) has expressed his intention of making the annual inspection of the corps during their stay in camp.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

An ordinary quarterly Comitia was held at the College on Thursday, July 29th, the President, Sir R. Douglas Powell, in the Chair.

Membership.

The following candidates, having passed the required examination, were admitted Members of the College:

Edwin Greaves Fearnsides, M.A., M.B.Cantab., L.R.C.P., William Errington Hume, M.B.Cantab,, James Lindsay, M.D.Edin., Henry MacCormac, M.B.Edin., Walter Malden, M.A., M.D. Cantab., Arthur Hallowes Miller, M.B.Cantab., L.R.C.P., Patrick Thomas O'Sullivan, M.D.Roy. Univ., Irel., Leonard Gregory Parsons, M.D.Lond., L.R.C.P., Ivy Evelyn Woodward, M.D. Lond.

Licence.

Eighty-six candidates having passed the necessary examination were granted the Licence of the College to practise Physic.

Diplomas in Public Health.

In conjunction with the College of Surgeons, Diplomas in Public Health were granted the following gentlemen:

Andrew Allison, M.B., Ch.B.Glasg., Hugh Barr, M.B., Ch.B.Glasg., James Aylmer Beamish, M.B., B.Ch., R.U.I., Harry Boulcott Bolus, M.B., B.C.Cantab., L.R.C.P., M.R.C.S., Clement Henry Burton Bradley, M.B., Ch.M.Sydney, L.R.C.P., M.R.C.S., Thomas Evans, M.B.London, James Fairley, M.B., Ch.B. Glasg., Robert Mylcraine Freer, M.D., C.M.Edin., Walter Ernest Fry, L.R.C.P., M.R.C.S., Henry William Harding, L.R.C.P., M.R.C.S., M.D.Lond., Richard Athelstane Parker Hill, M.B.Cantab., L.R.C.P., M.R.C.S., Thomas Edward Holmes, M.D., B.C.Cantab., Herbert Edward Littledale, M.D., B.Ch.Dublin, Walter St. Clair McClure, L.R.C.P., M.R.C.S., Krishnaji Shripat Mhaskar, M.D., L.M. & S., Bombay, Richard Alfred O'Brien, M.D., B.S.Melb., Percy William Spaull, L.R.C.P., M.R.C.S.

International Medical Congress.

The President announced that he had received a communication from the Secretary of State for Home Affairs, requesting him to nominate a delegate to represent this country at the International Medical Congress to be held at Budapest this year. He nominated Dr. F. W. Pavy, who had already been elected to represent the College at the Congress.

Murchison Scholarship.

A report was received from the Examiners for the Murchison Memorial Scholarship at Edinburgh, stating that as the result of the recent examination the scholarship had been awarded to Mr. Alexander Gibson, M.A., M.B., and that Mr. G. C. Greenfield, M.B., had been "*Proxime accessit.*"

Emeritus Registrar.

On the motion of the Senior Censor, Dr. Norman Moore, seconded by Dr. P. W. Latham, Dr. E. Liveing was elected Emeritus Registrar by acclamation.

Communication.

The following communication was received: From the Secretary of the College of Surgeons reporting proceedings of their Council on July 8th.

Censors and other College Officers.

On the nomination of the President, the Council, and the Library Committee, the following gentlemen were elected Censors, other College Officers, and Examiners:

Censors: Sir William Henry Allchin, M.D.; Francis de Havilland Hall, M.D.; Seymour John Sharkey, M.D.; James Kingston Fowler, M.D. *Treasurer:* Sir Dyce Duckworth, M.D. *Registrar:* Joseph Arderne Ormerod, M.D. *Harveian Librarian:* Joseph Frank Payne, M.D. *Elected Members of the Library Committee:* Norman Moore, M.D.; William Osler, M.D.; Arthur Francis Voelcker, M.D.; Charles Arthur Mercier, M.D. *Curators of the Museum:* Sir William Henry Allchin, M.D.; Seymour John Sharkey, M.D.; William Hunter, M.D.; Frederick William Andrewes, M.D. *Finance Committee:* Francis Henry Champneys, M.D.; George Newton Pitt, M.D.; Herbert Pennell Hawkins, M.D. *Examiners.—Chemistry:* Wm. Holdsworth Hurtley, D.Sc.; George Senter, Ph.D., B.Sc. *Physics:* Dawson, F. D. Turner, M.D.; Alfred Henry Fison, D.Sc. *Practical Pharmacy:* Arthur Philip Beddard, M.D.; Edmund Ivens Spriggs, M.D.; Robert Arthur Young, M.D.; William James Fenton, M.D.; Alfred Ernest Russell, M.D. *Physiology:* William Dobinson Halliburton, M.D.; Marcus Seymour Pembrey, M.D. *Anatomy:* Christopher Addison, M.D. *Medical*

Anatomy and Principles and Practice of Medicine: Wilmot Parker Herringham, M.D.; Richard Grainger Hebb, M.D.; Sidney Harris Cox Martin, M.D.; Herbert Pennell Hawkins, M.D.; Humphry Davy Rolleston, M.D.; Sir Edwin Cooper Perry, M.D.; Sir Hugh Reeve Beevor, Bart., M.D.; James Galloway, M.D.; Wilfred James Hadley, M.D.; Laurence Humphrey, M.D. *Midwifery and Diseases peculiar to Women:* Herbert Ritchie Spencer, M.D.; George H. Drummond Robinson, M.D.; Arthur Hamilton Nicholson Lewers, M.D.; Arthur Francis Stabb, M.B.; George H. A. Comyns Berkeley, M.D. *Public Health:* Part I, William Henry Willcox, M.D., B.Sc.: Part II, Alexander Grant Russell Foulerton, F.R.C.S. *Murchison Scholarship:* David Bridge Lees, M.D.; Horace George Turney, M.D. The newly-elected officers, examiners, and members of standing committees gave their faith to the college.

Baly Medal.

On the same recommendation of the Council, the Baly Medal, for distinction in the Science of Physiology, was awarded to Emil Fischer, Ph.D., Professor of Chemistry, University of Berlin.

Moxon Medal.

On the same recommendation, the Moxon Medal, for distinction by observation and research in Clinical Medicine, was awarded to Sir William Gowers, M.D., F.R.S.

Committee of Management.

The Registrar, Dr. Ormerod, was elected a member of the Committee of Management in the place of Dr. E. Liveing, who had resigned.

Imperial Cancer Research Fund.

Dr. Sidney Martin, who retired by rotation, was re-elected a member of the Executive Committee of the Imperial Cancer Research Fund.

Reports.

The following reports were received:

1. From Dr. Norman Moore on the Darwin Commemoration at Cambridge, June 21st to 25th.
2. From Dr. Habershon on the celebration of the 350th Anniversary of the Foundation of the University of Geneva, July 7th to 10th.
3. From the Standing Committee on Beri-beri after a meeting held on May 19th last.
4. The Annual Report of the Imperial Cancer Research Fund.
5. From the Committee of Management, dated June 29th, recommending—

(*a*) That the London County Asylum at Long Grove, Epsom, be added to the list of lunatic asylums recognized by the Examining Board in England.

(*b*) That the Western Reserve University, Cleveland, Ohio, United States, be added to the list of institutions at which the curriculum of professional study required for the diplomas of the Royal Colleges may be pursued and whose graduates may be admitted to the final examination of the Examining Board in England, on the production of the required certificates of study.

Both recommendations were adopted.

6. From the same Board, dated July 13th, recommending that Mr. R. J. Godlee be appointed visitor to the examinations of the Egyptian School of Medicine for the examinations to be held in December next.

The recommendation was approved.

7. The Quarterly Report of the College Finance Committee, dated July 15th.
8. The Annual Report of the Library Committee.
9. The Annual Report of the Curators of the Museum.
10. The Quarterly Report of the Examiners for the Licence on the results of the examinations in April last.

Library.

Books and other publications presented to the library during the past quarter were received, and thanks returned to the donors.

Obituary.

DEATHS IN THE PROFESSION ABROAD.—Among the members of the medical profession in foreign countries who have recently died are Dr. Bondet, sometime Professor of Clinical Medicine in the Medical Faculty of Lyons, aged 78; Dr. Gustav Christian Lott, Professor of Obstetrics and Gynaecology in the University of Vienna, and author of writings on the anatomy and physiology of the cervix uteri, and many other contributions to the literature of his speciality, aged 66; Dr. Amédée Monteils, member of the General Council of Mende, and sometime representative of La Lozère in the French Chamber of Deputies; Dr. August Vogl, Ritter von Fernheim, Professor of Pharmacology and Pharmacognosis in the University of Vienna, of which he was Rector in 1887–8, besides being more than once Dean of the Medical Faculty, in his 75th year; and Dr. Gustave Gauthier, formerly representative of the Haute Saône department in the French Senate.

The Services.

INDIAN MEDICAL SERVICE.

AT the examination on July 31st for 21 commissions in the Indian Medical Service there were 48 candidates. The highest number of marks obtainable was 5,100. The following were successful:

	Marks.		Marks.
C. H. Smith	3,997	D. G. Cooper	3,366
A. M. Dick	3,840	W. L. Forsyth	3,333
T. J. C. Evans	3,733	K. S. Thakur (Punjab) ...	3,288
R. J. Binning	3,712	M. A. Rahmar (Bombay) ...	3,281
M. J. Holgate	3,512	F. J. Kolaporewalla (Poona)	3,258
J. McD. Eckstein	3,503	H. R. B. Gibson	3,257
T. L. Bomford	3,471	D. Arthur	3,252
W. A. M. Jack	3,433	E. H. V. Hodge	3,225
G. R. Lynn	3,412	G. T. Burke	3,187
L. H. L. Mackenzie	3,404	R. H. Barucha (Bombay) ...	3,143
A. C. Anderson	3,385		

EXAMINATION FOR PROMOTION, HOME STATION.

THE following is the list of successful candidates at the May examination for promotion of majors of the Royal Army Medical Corps on technical subjects:

Major L. WAY, Sanitation and Epidemiology. Already passed in (*d*) ii, in Army Medical Organization in Peace and War, and in Medical History, etc.

Major G. A. T. BRAY, Technical Subjects; .8 in Medical History, etc. Already passed in (*d*) ii.

Major J. D. FERGUSON, D.S.A., (*d*) ii. Already passed in Technical Subjects.

Major E. E. POWELL, Army Medical Organization in Peace and War. Already passed in (*d*) ii, in Sanitation and Epidemiology, and in Medical History, etc.

Major O. L. ROBINSON, Technical Subjects; .8 in Medical History, etc. Already passed in (*d*) ii.

Major E. H. CONDON, M.B., (*d*) ii, and in Technical Subjects.

Majors B. W. LONGHURST and C. T. SAMMAN (*d*) ii, have yet to pass in Technical Subjects.

Major C. M. FLEURY, (*d*) ii. Has yet to pass in Sanitation and Epidemiology.

Majors W. TIBBITS, M.B., and A. W. HOOPER, D.S.O., (*d*) ii. Have yet to pass in Technical Subjects.

Captain W. H. S. NICKERSON, V.C., M.B., (*d*) ii; .75. Already passed in (*h*).

Captains M. M. LOWSLEY and H. B. G. WALTON, (*d*) ii. Already passed in (*h*).

Captains H. M. MORTON, M.B., and E. W. SIBERY, (*d*) ii; .75. Already passed in (*h*).

Captain J. A. HARTIGAN, M.B., (*d*) ii. Already passed in (*h*).

Captains B. S. BARTLETT, J. G. CHURTON, C. H. FURNIVALL, and E. BENNETT, (*d*) ii; .75. Already passed in (*h*).

Captain A. J. W. WELLS, (*d*) ii. Has yet to pass in (*h*).

Captain P. G. EASTON, (*d*) ii; .75. Has yet to pass in (*h*).

Lieutenant A. C. VIDAL, (*d*) ii, and in (*h*) ii and iii. Has yet to pass in (*h*) i.

Lieutenants C. CASSIDY and A. FORTESCUE, M.B., (*d*) ii and in (*h*) ii and iii; .75 in (*d*) ii. Already passed in (*h*) i.

Lieutenant M. P. LEAHY, M.B., (*d*) ii and in (*h*) iii. Already passed in (*h*) i and ii.

Lieutenant W. G. AVISS, (*d*) ii and in (*h*) ii and iii. Already passed in (*h*) i.

Lieutenant G. F. DAWSON, M.B., (*d*) ii and in (*h*) ii and iii; .75 in (*d*) ii and .8 in (*h*) ii and iii. Already passed in (*h*) i. Special Certificate.

Lieutenant H. V. B. BYATT, (*d*) ii and in (*h*) ii; .75 in (*d*) ii. Has yet to pass in (*h*) iii. Already passed in (*h*) i.

Lieutenant F. J. STUART, M.B., (*d*) ii and in (*h*) ii and iii. Has yet to pass in (*h*) i.

Lieutenant J. A. RENSHAW, (*d*) ii and in (*h*) ii and iii; .8 in (*h*) ii and iii. Already passed in (*h*) i.

Lieutenant R. DE V. KING, (*d*) ii and in (*h*) ii and iii. Already passed in (*h*) i.

Lieutenant D. B. MCGRIGOR, M.B., (*d*) ii and in (*h*) ii and iii. Has yet to pass in (*h*) i.

Lieutenant R. G. S. GREGG, M.B., (*d*) ii and in (*h*) ii and iii. Already passed in (*h*) i.

Lieutenant W. A. SPONG, M.B., (*d*) ii and in (*h*) ii and iii; .75 in (*d*) ii and .8 in (*h*) ii and iii. Already passed in (*h*) i. Special Certificate.

Lieutenant H. P. HART, M.B., (*d*) ii and in (*h*) ii and iii. Already passed in (*h*) i.

Lieutenants A. E. B. JONES, M.D., and A. HENDRY, M.B., (*d*) ii and in (*h*) ii and iii. Have yet to pass in (*h*) i.

Lieutenant J. F. GRANT, M.B., (*d*) ii and in (*h*) ii and iii. Already passed in (*h*) i.

THE ROYAL ARMY MEDICAL CORPS (TERRITORIAL FORCE).

TRANSPORT TO GENERAL HOSPITALS.

IN his paper on transport to general hospitals, published in *National Defence* and noticed in our issue of July 24th, p. 243, Dr. Bowser mentioned that the Great Central Railway was the only company in possession of a railway ambulance coach. Mr. E. A. Richards, Secretary of the South-Eastern and Chatham Railway Centre of the St. John Ambulance Association, writes to inform us that that company has an ambulance saloon equipped in every respect, which is constantly in use for the conveyance of hospital cases. Mr. Richards also forwards prints of the coach taken from their last annual report.

Medico-Legal.

LIABILITY FOR FEES.

C. H. writes: A child is in need of a surgical operation; the mother, who is present, requests me to perform the operation; the father, who is absent, objects to the operation, unknown to me at the time. The operation is successfully performed, and the child recovers. The wife's income depends upon her husband, who repudiates liability for fees. Will you kindly inform me if there is any legal redress?

*** If the operation was urgent the father is legally liable. But there might be operations where the consent of the father would be necessary to make him responsible for the fees. At common law the wife is only the agent of her husband, and this agency may be repudiated by the latter. Cases bearing on this are: Montague *v.* Benedict (3 B. and C. 631), Seaton *v.* Benedict (2 M. and P. 66), Jolly *v.* Rees (33 L.J.C.P. 177).

TENANTSHIP AND CANCER.

A correspondent writes: Was I, in point of law, compelled, before taking a furnished house, to give my landlady notice of the nature of my wife's complaint, namely, malignant disease of the breast with secondary bronchial glandular infiltration, cough, etc.?

*** Our correspondent was under no legal obligation to give notice of the nature of his wife's complaint.

Public Health AND POOR LAW MEDICAL SERVICES.

REPORT OF MEDICAL OFFICER OF HEALTH.

King's Norton and Northfield Urban District.—Dr. Reginald Green, Medical Officer of Health for the King's Norton and Northfield Urban District, has just issued his report on the work of the health department for 1908. The population was estimated at 78,608. The birth-rate was 25.54 per 1,000 of the population, being the lowest on record. The births numbered 1,929, the males being in a decided majority—1,015 to 914 females. The death-rate was 10.78 per 1,000, the same as in 1907. The rate of infant mortality was 86 per 1,000 births, the average for the past ten years being 107. Of 1,934 births in this district, 1,472 children were vaccinated—a proportion to the whole of 76.1 per cent. This was 7 per cent. less than in 1907, and was due to conscientious objectors becoming more numerous as the facility with which they could obtain certificates of exemption increased.

EXTRA FEE FOR TREATMENT OF FRACTURE.

Argus.—In reply to our correspondent, we judge from his query that he has no contract covering such services; we are therefore of opinion that a fee of £3 is payable for the operation of setting the fracture and the subsequent attendance. In this case it appears that there was no subsequent attendance, and hence no claim can be made under the Order of the Local Government Board. But the matter being one of sudden and urgent necessity, the guardians may pay such sum as they may consider reasonable.

FEES FOR CERTIFICATION OF WORKHOUSE LUNATICS.

A correspondent writes: In May, 1903, A., the medical officer to a workhouse, and B., another practitioner, examine a patient in the workhouse, and certify that he is an idiot and fit to be detained in the workhouse, and are each paid the legal fee. In April or May of this year the Commissioner in Lunacy finds that the report of B. is dated May 13th, 1903, whereas the magistrates' order and the medical officer's report are dated May 8th, and states that it is necessary to obtain fresh certificates for the patient's legal detention. At the instigation of the guardians the patient was re-examined by A. and B., and fresh certificates with the magistrates' order were prepared. Are the medical officer and other practitioner entitled to another fee, as they claim that it was not their fault that the first certificates were wrong, and that they had exactly the same amount of work to do in the second examination as in the first?

*** We are of opinion that B., who signed the first certificate on May 13th, 1903, is fairly entitled to a second fee for having again (after the expiration of a period of five years) certified the same patient, as the latter duty must have been a no less responsible and onerous one than the first. We do not understand on what grounds A., the medical officer of the workhouse, can establish a claim to a fee for either his first or second certificate.

Letters, Notes, and Answers.

BRITISH MEDICAL ASSOCIATION AND BRITISH MEDICAL JOURNAL.

THE offices of the British Medical Association and of the BRITISH MEDICAL JOURNAL are at 429, Strand, London.

COMMUNICATIONS respecting Editorial matters should be addressed to the Editor, 429, Strand, London, W.C.; those concerning business matters, advertisements, non-delivery of the JOURNAL, etc., should be addressed to the Office, 429, Strand, London, W.C.

TELEGRAPHIC ADDRESS.—The telegraphic address of the EDITOR of the BRITISH MEDICAL JOURNAL is *Aitiology, London.* The telegraphic address of the BRITISH MEDICAL JOURNAL is *Articulate, London.*

TELEPHONE (National):—
2631, Gerrard, EDITOR, BRITISH MEDICAL JOURNAL.
2630, Gerrard, BRITISH MEDICAL ASSOCIATION.
2634, Gerrard, MEDICAL SECRETARY.

ORIGINAL ARTICLES and LETTERS *forwarded for publication are understood to be offered to the* BRITISH MEDICAL JOURNAL *alone unless the contrary be stated.*

AUTHORS desiring reprints of their articles published in the BRITISH MEDICAL JOURNAL are requested to communicate with the Office, 429, Strand, W.C., on receipt of proof.

CORRESPONDENTS who wish notice to be taken of their communications should authenticate them with their names—of course not necessarily for publication.

CORRESPONDENTS not answered are requested to look at the Notices to Correspondents of the following week.

MANUSCRIPTS FORWARDED TO THE OFFICE OF THIS JOURNAL CANNOT UNDER ANY CIRCUMSTANCES BE RETURNED.

In order to avoid delay, it is particularly requested that ALL letters on the editorial business of the JOURNAL be addressed to the Editor at the Office of the JOURNAL, and not at his private house.

☞ *Queries, answers, and communications relating to subjects to which special departments of the* BRITISH MEDICAL JOURNAL *are devoted will be found under their respective headings.*

QUERIES.

P. J. M. asks for information as to the suitability of La Bourbonne for rheumatoid arthritis.

SENEX would be grateful for some information about Eltham (Kent). Is the soil gravelly, or clay; dry or wet? Is the rainfall high, and does it suffer much from fogs? Is it looked upon as a healthful place, or otherwise?

IERNE asks if any reader can recommend a place in the British Islands in which the climate is suitable for children suffering from adenoids. Is there any place in which "adenoids" is practically unknown among the native population?

W. H. would be obliged if some reader could tell him of a mincer or other apparatus for finely dividing food, that could be used at meals. He has two old patients, 90 years old, and it is difficult to find anything, in the nature of animal food, that they can masticate and swallow.

DR. ROBERT J. SIMONS (Bridgend, South Wales) writes: I would feel very greatly obliged if you could give me the names of any books dealing with the art of medicine among primitive peoples and among the ancients. Among other things, I wish for information about necromancy, charms, amulets, philtres, and other methods of the dark ages. Any information as to where I might get some knowledge of the dawn of medical science would cause me to be greatly indebted to you.

ORGANIC CHEMISTRY EXAMINATION AT LONDON UNIVERSITY.

NIL DESPERANDUM writes: Would any brother from an atmosphere of learning kindly tell an isolated country practitioner what would be the best books to read for the Organic Chemistry of Part I of the Second Examination for Medical Degrees of the University of London, and where the chemicals and apparatus necessary for the practical work could be obtained?

*** The most suitable books for the London examination in Organic Chemistry are (*a*) in theoretical work, Bunge's *Organic Chemistry for Medical Students*, translated by Plimmer and published by Longmans; (*b*) in practical work, *Practical Organic Chemistry*, by Plimmer, published at University College in two parts (both of these are necessary). They can be obtained on application to the Secretary, University College, Gower Street, W.C., and cost 6s. for the two parts. We fear that our correspondent would have almost insuperable difficulties in preparing himself for the practical part of the examination, and our advice is that he should take out a practical course at some institution. The cost of chemicals and apparatus would be great for a private individual, as such apparatus as reverse condensers, etc., are essential. But if he wishes to buy the chemicals for himself, Messrs. Griffin (Kingsway, W.C.) are a respectable firm, in whose hands he would be safe. He would need to spend about four weeks on practical work, if he tried to work through a course at a recognized institution.

HOSPITAL OR DISPENSARY.

L. H. writes: A benevolent lady has started a movement and wishes to endow a hospital for chest diseases, which at present, until developed, will be for out-patients only. We propose having it in the metropolis. It was suggested at the last meeting that, as there were no beds at present, we could not perhaps call it "hospital." I have been desired to ask you if such would be out of place. We propose putting "hospital," with "out-patients" in brackets, until the beds are provided.

*** An institution for out-patients only is usually called a dispensary. We think it would be misleading to the public to describe it as a hospital.

ANSWERS.

COCAINE IN PARTURITION.

DR. J. SKARDON PROWSE (Manchester) writes: In reply to "Stockton," who (in the JOURNAL of July 31st) asks for experiences in the use of cocaine during the first or second stage of labour, I send a short account of the effects noted in a number of cases in which I used the drug some years ago. I employed the cocaine in about thirty-three labours, occurring among both primiparous and multiparous patients, with ages ranging from seventeen to forty-four years, chiefly for the relief of a painful and prolonged first stage, due to an unyielding os; but also, in some cases, where delay arose in the second stage from rigidity of the perineum; and in several, for relief of pain during the repair of perineal tears. In cases of rigid os, I either made use of a ½-grain suppository, passing it into the os, and retaining it with a tampon, or applied a 10 per cent. solution of cocaine to the parts with a brush, or a pledget of cotton wool. For rigid perineum, and for repair of ruptures, I used the solution of the same strength. In more than half the cases of delay in the first stage, from rigidity of the os—especially in neurotic women—the immediate results were happy; the os softening and dilating rapidly, the pains becoming less severe, and labour, in consequence, progressing as desired. In the remainder of these patients no particular effect was noted. With several women, in whom an unyielding perineum was the source of suffering and delay, the application of the cocaine appeared to render the pains less trying; but there was no evidence that it had any action towards softening the tissues, or making the perineum more elastic. Where the perineum was torn, the use of cocaine, naturally, enabled me to suture the wound with comparative comfort to the patients. So far, so good; but I think, judging solely from my own experience, there is a serious drawback to the use of this drug during labour; for, with the exception of seven, all my cases had a varying degree of *post-partum* haemorrhage; and the haemorrhage was less easily controlled than usual. Two of them, an alcoholic of 37, and a primipara of 28, suffered from the most severe attacks of *post-partum* bleeding which it has been my fortune to deal with. Apart from these "cocainized" cases, my midwifery practice has fortunately been very fairly free from this unpleasant complication. I believe, therefore, that I am justified in attributing the increased tendency to haemorrhage, observed in these cases, to the influence of the cocaine used. It will be interesting to learn if others have had any similar experiences.

DR. S. E. ATKINS (Exeter) writes: Replying to "Stockton," I have found the use of cocaine locally to the os uteri in the first stage bring about a rapid dilatation, but the results are not always constant. The form I use is that of a thimble, which fits on the top of the examining finger, and is left behind in close apposition to the os. Each contains 2 grams of cocaine, with a little boric acid, with coca butter as a base. They are prepared by Ferris, of Bristol.

LETTERS, NOTES, ETC.

DR. A. C. has not enclosed his card.

THE MEDICAL TREATMENT OF SCHOOL CHILDREN.

MR. GRIFFITH C. WILKIN (Paignton) writes: The medical profession will be wise to keep an eagle eye on this. The London County Council considered on July 27th the report of the Education Committee on this subject. It will be well for doctors to watch carefully every step taken by this most unfriendly committee. The Education Committee is practically suggesting that the treatment shall be done by the hospitals, and many of the hospitals—bodies that have always been supported by the profession—are base enough to eagerly offer their services. It is the duty of the Association to act at once, lest this pauper country should again fleece the doctors.

ANTIDIPHTHERIA SERUM IN ASTHMA.

DR. H. A. CLOWES (London) writes: In the early part of the year—I forget the exact date—the *Oxford Times* contained the report of an inquest on the body of a young woman who had died immediately after the injection of a prophylactic dose of diphtheria antitoxin. She was in apparently good health, but had suffered from asthma, and had had diphtheria some time before; but as diphtheria had occurred in the house in which she was living the doctor in attendance gave her an ordinary prophylactic dose of antitoxin, when she died in a few minutes from acute dyspnoea. The medical evidence was to the effect that death was due to acute asthma induced by the injection of diphtheria antitoxin, and a verdict was given in accordance with this evidence. It is evident from this case that antidiphtheria serum should be given with great caution to asthmatic patients.

TREATMENT OF INGROWING TOENAIL.

DR. J. BROOM (Kirriemuir, Forfar) writes: May I suggest, in reference to Dr. Tytler's memorandum (BRITISH MEDICAL JOURNAL, July 17th, p. 141), about the treatment of ingrowing toenail, a procedure I have followed for some years? It consists in splitting the fleshy part of the toe which covers the ingrowing point by inserting the point of the knife alongside the ingrowing nail and cutting straight out through the point of the toe, and then easing the point up and putting a fragment of linen below the point. The point of the nail will grow out and require no tearing off of the nail. It is of the utmost importance to get the patient to wear bigger boots and square toes; this is a vital matter in all such cases.

O.H.G. writes: Referring to recent correspondence as to the treatment of ingrowing toenail, it was in the columns of the BRITISH MEDICAL JOURNAL of November 13th, 1886, I learned of Dr. Miall's tannic acid method of treatment of ingrowing toenail. The procedure seemed so simple that I tried it on the first case that presented itself, and with highly satisfactory results. Since then I have abandoned all other lines of treatment, and the surgeon's knife has altogether been dispensed with. The Miall treatment of this troublesome affection cannot be too well known.

DR. W. HARDMAN, J.P. (Blackpool) writes: I am sure I cannot have treated fewer than 50 or 60 cases of this condition when I was in general practice. I cured all the cases rapidly and comparatively pleasantly by a very simple and common-sense procedure. It never failed in a single case, and I am sure some of the cases were as well marked and fully developed as any to be met with. I had seen cases treated in hospital a few times before I commenced practice, always by, as I think, the barbarous method—avulsion. I could not bear the thought of this unnecessarily cruel treatment, and as soon as I got a case I studied it, and found a mass of malodorous granulations overlapping the outer corner of the nail. This could, after soaking in warm carbolized water, be pushed aside, disclosing the nail corner. Examination showed this corner was dead, and had no attachment to the underlying bed. I got a strong, short-bladed, sharp-pointed pair of scissors, and wriggled it under the nail, and bit by bit cut off all the dead part. I then packed lint, moistened with carbolic lotion, between the nail edge and the granulating flesh, so as to push and keep the raw edge from the nail. I then wrapped a piece of lint, moistened with the same lotion, round the toe, covering all with gutta-percha tissue and a 1-in. bandage. Every day I repeated the soaking, and cut away more dead nail if I could. Usually the inflammation would be so much abated, and the toe so much less painful, that the patient could bear the manipulations better, and I could thoroughly complete what I might have left unfinished at the first sitting. The dressing was repeated as at first, and in a very short time the raw surface would be healed and the patient cured. I used always to examine the boots for malformation, and particularly the stockings. In my opinion the most common cause of this complaint is the constricting pressure of pointed-toed worsted stockings. These run up with washing, and very effectually compress the fleshy edge of the toe bed against the nail, hence the condition of not "ingrowing toe nail," but impressed toe bed edge. If the toe was very much inflamed and tender, I used lead and opium lotion instead of carbolic for a few days. I do not attribute the slightest curative virtue to the carbolic except that it prevented decomposition.

DR. CORDES (Marnex, Coppet, Vaud) writes: With a trifling operation I have had a constant success. I transfix the soft parts, just at the edge of the nail, taking away all the flesh, then applying a common dressing without suture. I remember two cases (being out of town I have no access to my notebook). The first one was a Chinaman, whose work was to climb a bamboo tree, using only his toes. After three days he was able to resume his occupation. I lost sight of him about a week after the operation. The second one I saw many times during a good many years. The disease never returned.

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